

Middlesex University Research Repository

An open access repository of

Middlesex University research

<http://eprints.mdx.ac.uk>

Burrell, Rachel-Rose (2019) The Black Majority Church: exploring the impact of faith and a faith community on mental health and well-being. Other thesis, Middlesex University / Metanoia Institute. [Thesis]

Final accepted version (with author's formatting)

This version is available at: <https://eprints.mdx.ac.uk/26479/>

Copyright:

Middlesex University Research Repository makes the University's research available electronically.

Copyright and moral rights to this work are retained by the author and/or other copyright owners unless otherwise stated. The work is supplied on the understanding that any use for commercial gain is strictly forbidden. A copy may be downloaded for personal, non-commercial, research or study without prior permission and without charge.

Works, including theses and research projects, may not be reproduced in any format or medium, or extensive quotations taken from them, or their content changed in any way, without first obtaining permission in writing from the copyright holder(s). They may not be sold or exploited commercially in any format or medium without the prior written permission of the copyright holder(s).

Full bibliographic details must be given when referring to, or quoting from full items including the author's name, the title of the work, publication details where relevant (place, publisher, date), pagination, and for theses or dissertations the awarding institution, the degree type awarded, and the date of the award.

If you believe that any material held in the repository infringes copyright law, please contact the Repository Team at Middlesex University via the following email address:

eprints@mdx.ac.uk

The item will be removed from the repository while any claim is being investigated.

See also repository copyright: re-use policy: <http://eprints.mdx.ac.uk/policies.html#copy>

Rachel-Rose Burrell [F2-DPR16103]

Module: DPY 5360 Project 360 Credits

Doctorate in Psychotherapy by Professional Studies

Middlesex University and Metanoia Institute

Final Project

Title: The Black Majority Church: Exploring the impact of faith and a faith community on mental health and well-being

Submitted: January 3rd 2019

Acknowledgements

I would like to thank the following individuals for their contribution to this project:

Academic Advisor Dr Christine Stevens; Dr Stephen Goss, Dr Marie Adams and Dr Sophie Bager-Charleson; Dr Onel Brooks; Dr Dawn Edge; Dr Kenneth Koenig, Professor Adam Dinham and Dr Peter Brierley for endorsing the study; Interview participants; Research assistant Claudine Ford; Father Britto; Bishop Michael White; Malik Gul and Bishop Delroy Powell; Bishop John Francis, Co-pastor Penny Francis and Ruach City Church; Ruach Research Group: Dr Niyat Henok and Adnan Moudhiddin; Ivor Ettiene at Ruach Radio; Sozo Therapeuo Team: Anita Vincent, Sonia Doughall, Yolanda Antonio, Sharon Walker and Claudine Ford; Pastor Errol Brown; Sharon Nugent; Eunice Amusu; Angela Gillard; The National Spirituality and Mental Health Forum; Alan Gadd and Faiths Together in Lambeth; Dr R. David Muir and The Pentecostal Network; Pastor Nims Obunge; Riana Lee; Evyon McPherson; Marie Reid at ChrispelMedia.com; Luke Allan website designer; Proof readers and critical friends Dr Emma Davies, Vimbai Shire, Anita Vincent and Lascelles Haughton; Friends for your support and prayers; My family for your support and encouragement; Thank you Jesus for help, strength and completion.

I dedicate this project to my parents Franklin Samuel and Linette Burrell

Table of Contents

Abstract.....	10
1.Introduction	12
1.1. Definition of The Black Majority Church	13
1.2. Aims of the Study.....	19
1.3. Background to the Study.....	22
1.4. Early Africans and Christianity.....	25
1.5. The Caribbean and Christianity.....	27
1.6. Early Presence of Black People in Britain.....	30
1.7. Migration to the UK.....	31
1.8. Pentecostalism in the UK.....	32
1.8.1. History of Pentecostalism.....	33
1.8.2. Growth of Pentecostalism in the UK.....	35
1.9. Black Mental Health in the UK.....	37
1.10. Spiritual Care and Health.....	38
1.10.1. Impact of Religion on Health.....	39
2. Literature Review	41
2.1. Traditional African Religion.....	41
2.1.1. Africa and Christianity.....	42
2.1.2. African Presence in Europe.....	47
2.1.3. The Nineteenth and Twentieth Centuries.....	47
2.1.4. The Holiness Tradition.....	49
2.1.5. Origins of Pentecostalism in the UK	49
2.1.5.1. Pentecostal Beliefs in the UK.....	50
2.1.5.2. Trinitarian and Oneness.....	51
2.1.5.3. Sabbatarianism.....	53
2.1.5.4. Pentecostal Practices in the UK.....	53

2.2. Overview of Christianity in Britain.....	56
2.2.1. Status of Christianity in the UK.....	56
2.2.2. Decline of Christianity in Britain.....	58
2.2.3. UK Growth of Christian Pentecostalism	59
2.2.4. Global Pentecostalism.....	59
2.2.5. Pentecostalism and Flexibility.....	60
2.2.6. Growth of Christian Pentecostalism in London.....	61
2.2.7. African Pentecostal Churches in London.....	62
2.2.8. Pentecostalism in Britain Today.....	65
2.2.9. BMCs' Wider Socio-Political Impact.....	66
2.3. Black People and Socio-economic Factors.....	69
2.3.1 Ethnicity, Ethnic Groupings in the UK.....	69
2.3.2. Race and Poverty.....	70
2.3.3. Race and Education.....	70
2.3.4. Race and Health.....	71
2.4. Mental Health.....	73
2.4.1. The Cost of Mental Health in the UK.....	74
2.4.2. Mental Health and Gender.....	75
2.4.3. Stigma.....	77
2.4.3.1. Black Mental Health	78
2.4.3.2. Black People and Statutory Mental Health Services.....	79
2.4.3.3. Cultural Context.....	82
2.4.3.4. Indentity.....	83
2.4.3.5. Mental Health and Migration	84
2.5. Religion and Mental Health.....	87
2.5.1. Religion and Spirituality	87
2.5.2. Religion and Psychiatry.....	92
2.5.3. The Positive Impact of Religion on Mental Health.....	96

2.5.3.1. The Negative Impact of Religion on Mental Health.....	98
2.6. Coping Strategies.....	104
2.6.1. Therapy	104
2.6.1.1. Therapy and Race	105
2.6.1.2. Black Client White Counsellor Dyad	107
2.6.1.3. Transcultural Therapy.....	108
2.6.2. Therapy and Religion.....	109
2.6.2.1. Christian Counselling.....	114
2.6.3. Therapy Training.....	115
2.6.4. Mental Professionals and Delivery of Services.....	118
2.6.5. Perceptions of Health, Illness and Healing.....	119
2.6.5.1. Pastors and Leadership Teams.....	122
2.6.5.2. Leaders' Influence on Interpretation of Problems	122
2.6.5.3. Black Leadership and Training.....	124
2.6.6. Religious Coping.....	125
2.6.6.1. Faith.....	127
2.6.6.2. Meditation.....	128
2.6.6.3. Prayer	129
2.6.6.4. Worship.....	132
2.6.6.5. Singing and Dancing.....	133
2.6.6.6. Faith Communities (Church).....	134
2.6.6.7. Church Attendance and Membership.....	134
2.7. Partnership Working.....	135
 3. Research Methods.....	 139
3.1. Focus Groups Research Questions.....	140
3.1.1. Semi-structured Interview Questions.....	141
3.1.2. Individual Interview Questions.....	145
3.2. Ethical Considerations and Administration.....	147
3.3. Participant Recruitment.....	149

3.4. Summary of Focus Group Process.....	154
3.4.1. Research Assistant.....	156
3.4.2. Participant Data Collection: Focus Group Interviews.....	157
3.4.2.1. Overview of Focus Groups.....	160
3.5. Summary of Individual Interview Process.....	164
3.5.1. Participant Data Collection: Individual interviews	164
4. Data Analysis.....	167
4.1. Transcription Process.....	167
4.2. Thematic Analysis.....	168
4.2.1. Narrative Analysis.....	171
4.3. Working with NVivo.....	172
5. Findings	175
5.1. Focus Group Themes.....	175
5.2. Summary of Findings.....	175
5.2.1. Participants' Responses in Relation to Demographic Information.....	185
5.3. Overarching Themes and Cluster Themes.....	191
5.4. Findings	229
5.4.1. Individual Interview Themes.....	229
5.4.2. Summary of Findings.....	229
5.4.3. Main Themes.....	230
6. Discussion.....	240
6.1. Summary of Findings: Combined Research Questions	240
6.1.2. Implications of Findings.....	244
6.2. The Social Care Model.....	261
6.3. A Safe Place.....	262
6.4. Looking Forward.....	262
6.5. Products and Reflections.....	264
7. Conclusion.....	289

Tables

Table 1. Focus Group Venues.....	156
Table 2. Illustration of Overarching Themes and Main Themes.....	192

Appendices.....291

Appendix 1: Definition of Terms

Appendix 2: Origins and Development of Christianity in Africa Timeline

Appendix 3 The Rise of Pentecostalism - Christian History Timeline

Appendix 4: Pentecostalism - Beliefs and Practices

Appendix 5: History of Christianity in Britain Timeline

Appendix 6 and 7: Racial Identity Models

Appendix 8: Focus Group Questions, Prompts and Follow-up Questions

Appendix 9: Ethical Approval Form

Appendix 10: Participant Letter of Invitation

Appendix 11: Participant Information Sheets

Appendix 12: Expression of Interest Form

Appendix 13: Follow-up Letter

Appendix 14: Focus Group Booking Form

Appendix 15: Consent Form

Appendix 16: Participants' Personal Information Sheet

Appendix 17: Focus Group Script

Appendix 18: Participants' Demographic Information

Appendix 19: Participants' Transcript Checking Instructions

Appendix 20: Original Codes/Nodes Focus Groups

Appendix 21: Original Codes/Nodes Individual Interviews

Appendix 22: Preliminary Map of Overarching Themes

Appendix 23: Table of Combined Themes

Appendix 24: Participants' Description of Barriers to Seeking Help

Appendix 25: Mental Health Awareness Training Programme

Appendix 26: Feedback - Mental Health Awareness Training

Appendix 27: Counselling Skills for Leaders Training Programme

Appendix 28: Feedback - Counselling Skills Training

Appendix 29: Training Manual - Mental Health Awareness for Churches

Appendix 30: Training Manual - Counselling Skills for Pastors and Leadership Teams

Bibliography.....	416
--------------------------	------------

Abstract

The study explores interpretations of problems, coping strategies and help-seeking behaviour of black Christians attending a Black Majority Church (BMC). BMCs (Pentecostal churches) are the fastest-growing group of Christians in the UK (Christian Research 2006). At the same time, black people continue to be over-represented in the mental health system compared to their white counterparts; are more likely to be diagnosed as 'schizophrenic'; more likely to be sectioned under the Mental Health Act and, since 2009, are more likely to be placed on community treatment orders (Mental Health Foundation 2014). A growing body of research exists on the role of BMCs in supporting individuals in distress (Bhugra 1997; Leavey 2004; Edge 2010). The qualitative study examines participants' perspectives on whether there are links between faith and belonging to a faith community, and mental health and well-being. Fifty-six participants (eleven males and forty-five females) took part in the study. A broad range of BMCs were represented, including New Testament, Apostolic, Independent and Catholic denominations. Eleven focus groups and eight subsequent individual interviews were conducted and transcribed verbatim, data was analysed using Thematic Analysis and Narrative Inquiry. Findings suggest that music, prayer, The Word (preaching, quoting/reading The Holy Bible) and belonging to a church provide a positive sense of well-being. Lack of understanding of mental health issues within the church, distrust, ignorance and leaders lacking adequate training and qualifications were cited as areas impacting negatively on mental health and well-being. Faith in God emerges as central to mental stability and well-being and was considered more effective and appropriate than therapy in some cases. Mistrust and suspicion of psychiatrists and mental health services was expressed by participants, often based on first- and second-hand experiences of the effects of medication, negative encounters, lack of understanding and little or no

access to talking therapies. Participants recovering from, or living with, mental health difficulties voiced a wish to be respected, to be treated with kindness, to receive a warm welcome when they attend church services and to be contacted regularly. A culture of acceptance, openness and destigmatising mental health problems, rather than spiritualising and demonising them, was emphasised. Participants stressed that leaders should be better equipped to deal with both the congregants' and their own mental health concerns. Examples of good practice and in-house counselling initiatives within black churches are identified. Products of the study include: the development of Sozo Therapeuo (N.B. not affiliated to any other similarly worded organisation), a mental health resource to promote, improve and maintain good mental health within BMCs; a therapist directory of qualified counsellors and psychotherapists; bespoke training packages and workshops designed to meet the needs of individual churches; Mental Health Awareness for Churches and Counselling Skills for Pastors training manuals following two pilot training events; Consultancies to churches setting up counselling services, such as Bethel Church, Bristol; 'Speak your Mind' radio show host promoting mental health on award-winning Ruach Radio; a church-based therapy forum and a network of church-based mental health champions who have received mental health awareness training.

(Key words: Black Majority Church, black people, faith, church, mental health)

Word count: 500

Title: The Black Majority Church: Exploring the impact of faith and a faith community on mental health and well-being

1. Introduction

As a psychotherapist, woman of colour and member of the leadership team in my own church, the subject of black mental health – prevention and intervention – is extremely important to me. The study will illustrate that, despite the range of support services available, certain areas are lacking and require attention to ensure the black Christian is adequately supported through times of emotional distress.

In the following pages the reader is invited to share an in-depth exploration of the influence of the Black Majority Church (BMC) on black mental health in the UK. Emphasis is placed on British research, the aim being to contribute to the growing body of knowledge in this country, as distinct from the USA, where considerable work already exists in the field. Time will be taken to define the Black Majority Church, charting its origin and development back through history to early African Civilization. An exploration of the wider context is presented, incorporating areas such as culture, socio-economic and political factors, as well as related topics including: mental health service provision, therapy training, design and delivery and their direct impact on black people's level of engagement with therapeutic services and treatment programmes. Black mental health is a dominant feature of the study, formulated in direct response to the over-representation of black people in the mental health (and prison) systems, and the fact that this has been the case for several decades. The interface between faith and therapy is also investigated and includes arguments on

both sides regarding support offered to black people experiencing mental health difficulties; but space is also given to failings, similarities and differences in relation to approach and outcomes. Religious faith (as opposed to spirituality), Christianity rather than other religions, and African-Caribbeans and Africans rather than other racial groups are central to the study to ensure attention and relevance is maintained, and due diligence given to the project title. Navigation through the research study will include the rationale, existing literature, method and results, with a comprehensive discussion of the findings in the appropriate sections. Activities and products emerging from the study will follow and recommendations for further work and personal reflections are made in the conclusion.

(See Appendix 1 for Definition of Terms)

It is hoped the reader will gain insight to, and a greater understanding of, the BMC and a deeper appreciation for its longstanding contribution to supporting individuals with both mental and physical ill health. In addition, the study aims to acknowledge areas for growth and change, and to recognise examples of successful partnership working and initiatives, all of which reflect the BMC's tenacity, impact and purpose in Britain today.

1.1 Definition of the Black Majority Church

There are several different definitions of the Black Majority Church (BMC); these are discussed below.

The BMC is a church which belongs to one of the larger denominations identified as originating in the black community, or an independent church originating in the black

community with a leadership and membership/congregation comprised mostly of black people, or any church in which the majority of the members/congregation is black, including Anglican, Roman Catholic and Baptist (Brown 1999). In addition, Clarke (2015) describes the Black Majority Church as a construct used primarily in Britain to define churches whose congregants hail from Africa or the African diaspora.

In a chapter entitled 'What on Earth is a Black Majority Church?', Sturge (2005) provides a helpful analysis of the term 'Black Majority Church' and identifies five segments: churches emerging from the African-Caribbean diaspora; churches emerging from the African diaspora; BMCs within the historic denominations, for example Anglican, Church of England, Methodist; BMCs within white Pentecostal denominations and African and Caribbean Spiritual churches. He proposes such churches are worshipping Christian communities comprised of fifty per cent or more people of African or African-Caribbean descent. However, the description 'BMC' is misleading because it implies that all black churches are the same, or that there is one single entity called the BMC within which all black churches sit. This is not the case; not all BMCs identify as Pentecostal, even though they may share similar practices. A number of churches emerged from a variety of historical, theological and ecclesiological roots. In the 1950s these churches were almost exclusively attended by Black Caribbeans and often were extensions of the churches that they belonged to in the West Indies.

Reddie (2006) prefers the phrase 'Black Church', which refers to a variety of Christian groups, Christian expressions and manifestations. He created a number of categories consisting of: Classical Pentecostal, Neo-Pentecostal and Black majority

people in historically white denominations, for example Anglican Pentecostals. Other writers, such as Kalilombe (1997), draw attention to the origins of the term 'BMC', taking issue with the designation of 'ethnic minority,' a classification 'imposed' on British black people in the 1980s. Anthropologist Toulis (1997) states 'ethnic minority' was introduced into public, political and academic discourse to identify 'settlers' in Britain. Right-wing political members understood the term 'ethnic minority' to mean 'unwanted cultural and racial aliens'. Kalilombe continues that concurrent with the introduction of 'ethnic minority', white-led churches 'imposed' the terms 'Black Christianity' and 'Black church' on black Christians, a form of segregation, much to the disapproval of BMC leaders at the time.

Aldred (2007) supports this in an address to the University of Birmingham entitled 'Black churches contributing to cohesion or polarising Christians and other faith groups?' Aldred demonstrates that white reactions to the new black churches were sociological not theological. The black churches were seen as divisive, militant and an inappropriate response to exclusion and oppression by engaging in Black struggle liberation. It was in the Directory of Churches in 1984 that the term 'Black-led Church' was first coined, applied by white church leaders. Black leaders rejected it, as this was not how they defined themselves; rather, they saw their mission as a universal one. Regarding the debate among black churches about how they should describe themselves, Arlington Trotman (1992), Pastor and Chief Executive Officer of the Churches' Commission for Racial Justice, maintains that 'it would be more precise if these churches were named according to their historical and theological foundations' because, the Body of Christ (the church) is not subject to colour, class or creed. Trotman's preferred classification for Black Church, was 'Holiness-Pentecostal Church'.

Scholar Yong (2006) refers to 'Black Pentecostal' and 'Afro-Pentecostalism' instead of BMC and is more concerned with Afro-Pentecostalism being recognised for its contributions to global Pentecostal theology by the wider Pentecostal academic community than with origins of the term. Adedibu (2012) uses the term 'Black Church', as it was this term that was used to describe early Pentecostals such as Thomas Brem-Wilson, a Ghanaian who pastored a Pentecostal congregation in London around 1904–1923. He uses the classification to include 'heroes of the faith', that is notable Christians from Africa and the African diaspora. Yong's classification further includes churches formed by the Windrush Generation, African Spiritual churches and the more recent African Pentecostal churches.

'Black-led' church is another synonym for BMC in Howard's (1987) comprehensive 'Report on Afro-Caribbean Christianity in Britain'. She uses the term to describe all local churches which have black leadership and where the membership is predominantly black. Like Sturge she agrees there are problems with the term 'Black-led church', especially if the leadership is not black despite there being large numbers of black people in the congregation. Sturge argues that the term 'BMC' firstly takes the focus from the leadership – as in 'Black-led' church, and places it on to the congregation; secondly, it crosses denominational and theological lines and in so doing provides a focus of unity (ibid).

Clarke's (2015) 'Empirical Study of Women in the British Black Pentecostal Church' found that black church leaders increasingly prefer the term 'black-led churches' to 'black churches', though some do object to it. It is a more accurate term because few churches are wholly black. Most have a handful of white members and would welcome more. Clarke adds that there is a determination to avoid the racial

discrimination that black people have felt in white-led churches, and some black church leaders expressed sadness that there are not more white people in their churches. Her view is the term 'black-led' emphasises positively that leadership is exercised by men and women whose ethnic background is seen as the main distinguishing factor. However, this term is problematic in that not all churches labelled as black churches are solely black. The majority of pastors and worshippers in British New Testament Church of God churches, for example, are African-Caribbean, although the parent church in the United States is predominantly white. Many churches which are almost entirely black and black-led in Britain have white denominational leadership in the United States (ibid).

'Charismatic' is another description given to BMC churches. Osgood (2012) investigates cotemporary Charismatic and Pentecostal churches and church groupings that are 'among' Britain's historic denominations, rather than 'within' them. In his paper he separates the strands of Pentecostal and Charismatic Christianity in Britain to highlight the diversity, extent and definable nature of the constituency, even though the strands may intertwine historically, theologically and practically. He describes the Pentecostal and Charismatic constituency bringing together all who embrace experientially those distinctive gifts of God's grace, the *Charisma* that are specifically listed as 'Gifts of the Holy Spirit' in 1 Corinthians 12:7–10, (love, prophecy, healing, wise speech, faith, miraculous and powers), and which made their first appearance at the Pentecost celebration immediately following Christ's crucifixion, resurrection and ascension, as described in Acts 2. The continuing growth of the constituency is both indigenously-propelled and diaspora-driven. It is a constituency that exists both within and among Britain's 'historic denominations'.

The term 'Evangelical church' is a synonym of the BMC, deriving from the Greek word εὐαγγέλιον' (transliterated as 'euangelion'), meaning 'good news'.

Evangelism is sharing the good news (known as the Gospel) of salvation that is available through Jesus Christ. An evangelical is a person dedicated to promoting the good news about Jesus Christ. Therefore an 'evangelical Christian' is a believer in Jesus Christ who is faithful in sharing and promoting the good news or the gospel. In contemporary Western culture, some believe an evangelical Christian is equivalent to a 'right-wing, fundamentalist Republican'. For others, 'evangelical Christian' is a title used to differentiate an individual from a Catholic Christian or an Orthodox Christian. Still others use the term to indicate adherence to the fundamental doctrines of Christianity. Many believe that being evangelical is an expectation of all Christians (GotQuestions.org).

'Born Again' is defined as 'of relating to, or being a Christian person who has made a renewed or confirmed commitment of faith especially after an intense religious experience' (Merriam-Webster's Collegiate Dictionary 2017). Some Pentecostal Christians describe themselves in this way, often as a result of baptism through acceptance of Jesus Christ, being immersed in water, resulting in a new life, or new birth, often evidenced by an inward change; many would describe it more as a transformation.

'Pentecostal' is an expression of Christianity founded on the Feast of Pentecost after's Christ's crucifixion. The story of Pentecost is told in the Bible, in the Book of Acts of the Apostles, Chapter 2:4–21. Pentecostalism gets its name from The Day of Pentecost, when the Holy Spirit descended on Jesus' disciples, leading them to speak in many languages as evidence that they had been baptised in the Spirit.

Pentecostals believe that this was not a one-off event, but something that can and does happen every day. Its roots go back to the eighteenth-century Wesleyan Holiness tradition, the nineteenth-century Holiness movement and the late-Victorian Keswick Higher Life movement.

The churches referenced in this study are categorised as 'classical' Pentecostals, a term which is associated with denominations that have beliefs through statements of faith and specific doctrines. These churches have a long-established history and trace their doctrinal origins to Wesleyan and Holiness traditions, applying Christian principles to everyday life. While a variety of definitions of the BMC exist, Sturge's definition will be used here as it best suits the needs of the project. Therefore, 'the BMC', 'BMCs' and 'Pentecostal Christianity' are used interchangeably throughout the study to encompass all types of BMC as described in his definition.

1.2 Aims of the Study

The focus of the research is the BMC and what factors affect congregants' mental health in relation to faith and belonging to a church. It examines how black Christians approach life's challenges and how the church responds to the mental health distress of its congregants.

The study explores the interpretation of problems, coping strategies and help-seeking behaviours of black people who identify themselves as Christian attending a BMC. The study will also examine participants' perspectives on whether there are links between faith, or belonging to a faith community, and their mental health and well-being.

The research attempts to show discrepancies in how black people (Christians and non-Christians) experience mental health and therapeutic services compared to their white counterparts in the UK. Similarly, poor management of mental health distress within black churches is identified, despite some churches attempting to address the issue with varying levels of success.

The significance of the leader/pastor of the church and how they might influence attitudes, interpretations and behaviours in relation to ill health and mental illness is also investigated and cannot be underestimated. Moving forward the study identifies current examples of good practice and areas for further development and change.

The study will argue the BMC has a significant place in the psychological care of its congregants and that faith and belonging to, or regularly attending, a church are central to health and well-being. However, creating a church culture that cultivates awareness, understanding and compassion around mental health is a key area. Products and initiatives developed out of the study to address this deficiency are highlighted in the discussion section. Accounts of the lived experience of black Christians living in the UK is offered, providing original research on how selected black Christians cope with mental health distress, and also identifying key mechanisms used to deter mental distress.

This study is a response to the scarcity of significant studies on the BMC and how it impacts black mental health. Given these areas are under-researched in the UK, the study seeks to add to this particular field of research which requires much more

attention. This qualitative study responds to the criticism that quantitative methodologies/studies dominate the field, often missing or losing some of the sensitivities and richness generated from qualitative work.

The project analyses the type and impact of church interventions when confronted with mental health concerns and conversely, examines how congregants feel about what is or is not offered in the form of support. The study shines a light on therapeutic services and other interventions within churches and examines the relationship between church and external statutory services regarding support for congregants and their families. The intention of the study is not to compare black with black, or black with white churches or to esteem one approach, style or intervention over another. The emphasis is on learning which elements could be useful in creating resources and services for black people when they need them most.

The study asks: 'How equipped do therapists feel to deal with race and religious issues in the consulting room?' And what are the implications for training institutions, placement managers and course designers responsible for teaching ethical and safe practice to their student bodies? How do they ensure sufficient time and discussion is given to difference and diversity in an inclusive and sensitive way when training new cohorts?

Comparing the different ways in which black Christians approach their problems may have implications on how secular agencies promote services, use therapeutic models and how treatment programmes are formulated. Some BMCs have been described as separatist, extremist, isolationist and reluctant to connect with other churches or helping professionals. This may give a greater sense of autonomy and responsibility,

but could this leave churches vulnerable and ill-equipped? Could they miss out on vital support and resources which could assist in managing mental health issues? The study will respond directly to these questions in the ensuing pages.

Equally, how proactive are secular services and white-majority churches in engaging and sharing with BMCs? The study aims, through its products, to generate dialogue between BMCs and the helping professions, as well as government officials and policy-makers; encouraging dialogue and exploration where all parties share good practice and ultimately work together within a culture of mutual respect.

The overall purpose of the study is not only to present compelling stories and narratives shared by the participants, nor merely to raise awareness of the BMC and black mental health, but to produce a robust, meaningful and useful project, the impact of which will be felt well beyond the submission of this study. The motivation to embark on this research project came from several sources, each having a lasting effect; the journey is described briefly below.

1.3 Background to the Study

As a student nurse in the 1980s, I was assigned a thirteen-week placement on a psychiatric ward in a large hospital in central London. Walking onto the ward for the first time I was shocked, frightened and confused. Most of the patients were black; ninety per cent were black men, their size intimidating. It was overwhelming; the situation felt threatening and I had never observed anything like this before. After conversations with the patients, I realised they were heavily medicated, communication was limited and they were harmless due to their medication-induced

drowsy-like state. These encounters remained imprinted in my mind and marked the start of my journey into this research area. I began asking questions, researching and adding my voice to other likeminded professionals who were equally appalled with the numbers of black people in the mental health system and campaigning for change. This, and many other experiences as a student and qualified nurse (and later a counsellor/psychotherapist), stimulated my interest in black mental health. The encounters raised questions, stirred emotions, leading me on a quest to find solutions. In one of my early jobs as a residential psychotherapist, my first client, a young black woman, refused to see me because I was black. I couldn't understand why; it was a very uncomfortable experience that left me feeling bewildered. It was later explained to me this was an example of 'internalised oppression', that of 'turning upon oneself, one's family and one's people the distress patterns that result from the racism and oppression of the majority society' (Lipsky 1978:5).

Post-qualifying as a counsellor, I approached senior leaders within the Pentecostal church I attended to gain their endorsement for a counselling initiative I wanted to implement in the church, following years of hearing congregants talk about their emotional and psychological struggles. The response I received was: '*There is no need for counselling when we have prayer.*' This perturbed me and raised many questions, not least of which was: Why does it have to be either/or; why not both?

The single two-hour lecture on diversity in counselling offered on my Masters course at a leading London university also left me perplexed at the little time assigned to what was and is, in my view, a huge and important community concern.

Leading psychiatrist and author Fernando (2012) proposes little has changed in the last fifteen years – black people are still over-represented in the mental health system compared to their white counterparts. They are between ten and twenty times more likely to be diagnosed as ‘schizophrenic’ (a severe long-term mental health condition which changes a person’s thoughts and behaviour); more likely to be sectioned under the Mental Health Act, or since 2009, placed on community treatment orders. They are also more likely to be deemed both ‘mad’ and ‘bad’ and so kept in forensic institutes and not referred to or accepted for counselling or psychotherapy. This therefore makes black people more likely to be subjected to medication rather than therapy. In his recommendations Fernando suggests that statutory services should engage with and learn from community services such as faith communities.

Similarly, black people are over-represented in the prison system in the UK, and many offenders have mental health problems. According to Black Mental Health UK (2017), people of African or Caribbean descent are 50 per cent more likely to be referred to mental health services via the police than their white counterparts. The scope of this project is limited and cannot address these troubling statistics, but will question whether socio-economic factors are the only reasons for these numbers.

Having attended BMCs since childhood, coupled with my background in mental health, this study draws on my personal experience as a black woman, a Christian and on my professional practice as a psychotherapist. I have a particular interest in the provision of holistic care that is physical, mental, emotional/psychological social, political and spiritual, both in terms of preventive and treatment interventions.

The project then, is shaped by my personal and professional experiences and pulls together elements central to my work and life, namely black people, Christianity, mental health and therapy; areas that reflect some aspect of me. It is acknowledged that these elements in and of themselves are huge subject areas, and that combining them generates a rich source of data, producing further themes, avenues of inquiry, questions and topics equally deserving of research. However, comprehensive interrogations of these vast topics are, unfortunately, precluded by limited time and resources at this stage.

In order to embed the project within a cultural context and provide a broader perspective on the issue of black Christianity and black mental health, an overview of early civilisation and the emergence of Christianity will follow.

1.4 Early Africans and Christianity

(See Appendix 2: Origins and Development of Christianity in Africa Timeline)

The oldest human fossil was recently discovered in Africa dating back 175,000 years (Quam, 2018). Scientific evidence supports the belief that humankind originated in Africa. Early Africans were innovators and pioneers, inventing musical instruments, tools, introducing the domestication of animals, excelling in art, architecture, commerce and trade (Osei, 1999). Clegg II (1996) records the invasion of ancient Africans around 40,000 B.C. who were among the first wave of humans to occupy Europe, conquering the Neanderthals.

The first indication of modern man in Europe is documented at 50,000 years ago; this people settled among the ice sheets of the south-western part of Eurasia (Russia), Archaeologists confirm them to be African (Africoid Grimaldi). Further scientific advances have uncovered Cheddar man – ancient DNA from Cheddar man, a Mesolithic skeleton discovered in 1903 at Gough's Cave in Cheddar Gorge Somerset – is the first modern Briton. He was a black African (Lotzof 2018).

Ancient Africans were a religious people, believing in one supreme God represented as Creator, Moulder, God of Destiny, Giver of Breath and Souls, Giver of Rain and Sunshine. They also believed in the existence of other spirits, because (hu)man was immortal, his spirit never died but lived beyond the grave, hence humans could communicate with spirits of the departed (Osei 1999).

The Christian communities in North Africa were among the earliest in the world, while the adoption of Christianity in Ethiopia dates to the fourth century, according to findings by the Metropolitan Museum of Art (BBC 2009). The Holy Bible also documents the conversion of an Ethiopian eunuch as the early church was forming (Acts 8:27–39). History records that Christianity was brought from Jerusalem to Alexandria on the Egyptian coast by Mark, one of the four evangelists, in 60 AD. This was around the same time or possibly before Christianity spread to Northern Europe.

Through North Africa, Christianity was embraced as the religion of dissent against the expanding Roman Empire. In the fourth century AD the Ethiopian King Ezana made Christianity the kingdom's official religion. In 312 Emperor Constantine made Christianity the official religion of the Roman Empire. In the seventh century Christianity retreated under the advance of Islam, but remained the chosen religion of

the Ethiopian Empire and persisted in pockets in North Africa. In the fifteenth century Christianity came to Sub-Saharan Africa with the arrival of the Portuguese. In the south of the continent the Dutch founded the beginnings of the Dutch Reformed Church in 1652. In other parts of the continent traditional religions were practised until the nineteenth century (BBC World Service, Christianity, the Story of Africa 2009).

By the advent of the slave trade and colonisation, Christianity and Islam were already well established throughout Africa. The European colonists sought to destroy or suppress traditional African religious practices which underpinned African society, replacing traditional practices through Christian missionaries, whose schools, along with their churches' teaching of languages, introduction of literacy and African converts, helped Christianity to spread quickly (Boahen 1990: 217–222). It is argued that Christianity had a disintegrating effect on African culture. The African response to Christianity was either acceptance, rejection or adaptation (ibid). According to Mbiti (1989), statistically, Christianity exploded in Africa during the twentieth century, resulting in two-thirds of the continent becoming Christian, while the northern third was predominantly Muslim.

1.5 The Caribbean and Christianity

Bisnauth (1989), introduces us to the first inhabitants of the West Indies arriving from South America, the Arawaks, followed by the Caribs, who probably originated from Brazil. At the time Christianity was being born, Arawaks migrated to the Lesser Antilles, the Bahamas, Cuba, Jamaica, Hispaniola and Puerto Rico. The Caribs migrated to Trinidad and eventually forced the Arawaks off the land. The Arawak Indians acknowledged the existence of one supreme, invisible, immortal and

omnipotent creator of all humankind and earth who they called Jocahuna. Jocahuna is not represented by any image and was regarded as gentle, benevolent and kind (like the Arawak people). Arawaks too believed in spirits which may interfere with human life, and thus evil spirits must be exorcised (ibid).

Bisnauth explains that Caribs believed that behind creation was one great universal cause which might be a superior, wise and invisible Being of great and irresistible power. No name was given to this Being, but far greater importance was placed on the earth. To them earth was not a god but a bountiful parent who provided all the good things in life. Both Arawaks and Caribs believed in the afterlife and that 'good behaviour' was a prerequisite to inheriting this. The Caribbean was invaded by the first Europeans at the same time as Alexander VI's ascension to the papal throne of Roderigo Borgio. Colonial rule followed, accompanied by the 'Christianising and civilising' of the Caribbean people.

Although there are many similarities between the Caribbean islands, they differ hugely with regard to culture and race. Differences in religious beliefs and practices are primarily due to their different colonial histories, which began in the 1650s (Howard 1987). During the great wars of the seventeenth and eighteenth centuries, Britain colonised Jamaica in 1655 and Trinidad in 1797 from Spain. By the end of the century Britain had also colonised Grenada, St Vincent, St Lucia and Dominica from France. Other countries included the Bahamas, Belize (then British Honduras) and Guyana (then British Guiana). In countries originally colonised by France and Spain the Roman Catholic Church predominates (except in Jamaica), whereas in Barbados the Anglican Church is the strongest church numerically (ibid).

Europeans enslaved Africans and brought them to the Caribbean as early as 1510, with numbers growing rapidly from 1517, when Africans were forced to take on heavy labour in the mines and fields of the West Indies. Although Africans tried to hold on to traditional religious practices, doing so was actively discouraged and even outlawed. Furthermore, life on the plantations was not conducive to observing religious rituals and tribesmen were often separated, destabilising their sense of community and identity. The enslaved Africans' belief in one supreme God survived the Atlantic crossing and brutal and oppressive living conditions. There was recognition that the God Almighty of the Christians was the same God they had always believed in. African religion became part of people's survival mechanism – perhaps the most important part. In pre-emancipation times Christianity was an important agent of social control. In post emancipation times, it would be an important vehicle for social mobility (Bisnauth 1989).

Bisnauth historical account notes further that in 1732 the first Catholic missionaries arrived in the Caribbean and the Christianisation of slaves began. Clergy sent by the Anglican Church to the West Indies were predominantly chaplains sent to the white landowners and overseers. For a century and a half slaves were not permitted into Anglican churches and Christian baptism, marriage and burial rites were denied, as slaves were considered equivalent to merchandise. In contrast, in the French- and Spanish-dominated islands some effort was made towards making slaves Christian by baptism.

Between the seventeenth to nineteenth centuries, slaves constructed a new religion – a combination of African religious practices combined with a reinterpretation of white supremacy Christianity. The black theology of liberation developed; a slave

religion of freedom formed underground. African Americans eventually surfaced at the end of the civil war in 1865 and black Christian slaves began to enjoy a faith which maintained their humanity and hope in a new heaven and earth for their children. Moravian missionaries were followed by Methodists, Baptists, Quakers and many other denominations (ibid).

Perhaps as many as 80–90 per cent of the Caribbean population became members of one or other of the Christian churches or sects. Hill (1971), estimated 69 per cent of the total population of the British West Indies attended regularly one of the six major denominations: Church of England, Roman Catholic, Baptist, Methodist, Congregationalist, Presbyterian, prior to the last major period of immigration in the 1950s.

1.6 Early Presence of Black People in Britain

Howard (1987) quoting Duffield (1981), writes that black people have been living in Britain since at least Roman times. There are well-documented references to black men and women at all levels of British society in the Middle Ages, and by the reign of Elizabeth I they were present in sufficient numbers for an attempt to be made to repatriate some of them (Fryer 1984). With the growth of the slave trade in the late-seventeenth century, it became increasingly popular for those who could afford it to have black servants or slaves. In 'Staying Power, History of Black People in Britain' Fryer estimated there were about 10,000 black people residing in Britain at that time.

The majority of black people in Britain in the eighteenth century were men and many of them married white women on gaining their freedom. There is evidence of much

inter-marriage in the nineteenth century and closely-knit black communities persisted in many British cities, numbers increasing further when large numbers of black people migrated to Britain in the early twentieth century. By this time some black people were beginning to gain prominence in public life, in the arts, medicine, sport, business, law and politics. Britain's black population increased again during the First and Second World Wars when seamen, munitions workers and others from the colonies rallied to fight for the Mother Country (Fryer 1984).

1.7 Migration to the UK

When the Second World War ended there was a shortage of labour in Britain, especially for jobs in textiles, heavy engineering, transport and healthcare. This factor was largely responsible for bringing about the most recent and largest increase of African-Caribbean migration to Great Britain, beginning in June 1948 when the Empire Windrush docked at Tilbury from Jamaica (Howard 1987).

With religion being an integral part of many Caribbeans' lives, on arrival to the UK they attended the Sunday services at historic churches in the new host nation and responded to sermons and songs as they normally would, with loud, vocally expressive and vibrant worship. The host congregation felt this style to be disruptive and inappropriate compared to their more sedate and passive way of worship, and the new black Christians were asked to leave. In response, black Christians formed their own churches, often starting in homes and expanding to halls and hired rooms until enough capital was accumulated to buy church properties. Countless stories exist describing experiences of black Christians arriving in Britain and trying to take their places in the denomination they belonged to from home. Stories of white congregants refusing to sit in pews with black congregants, of being told by the vicar,

‘Your people meet down the road’, or, ‘I’d prefer if you didn’t come again’ (Aldred 2016).

1.8 Pentecostalism in the UK

(See Appendix 3: The Rise of Pentecostalism – Christian History Timeline)

The Welsh Revival of Evan Roberts in 1904 was the catalyst for the Pentecostal Movement in Britain, however, it was the influence of the Azusa Street Revival (discussed below) on T.B. Barratt from Norway, Cecil Polhill and Alexander A. Boddy that led to the start of Pentecostalism in Britain. Boddy (1854–1930), an Anglican priest in Sunderland is considered the father of Pentecostalism in Britain because from 1907 his church became a meeting point where different people came to experience the baptism of the Holy Spirit. Both Smith Wigglesworth (1859–1947), prolific writer and a pioneer of faith, and Rev. Kwame Brem-Wilson (1906–1929) a Ghanaian businessman, experienced the baptism of the Spirit during a revival meeting. Rev. Brem-Wilson moved to Britain in 1901 and in 1906 became the first African Pentecostal leader at Sumner Road Chapel in Peckham, South East London. As a result of his attendance and contribution at the revival meetings in Sunderland in 1907, Rev. Brem-Wilson developed relationships with Alexander Boddy and Cecil Polhill who were founders of the first Pentecostal Missionary Movement in Britain: the Pentecostal Missionary Union. These relationships were significant at that time when it was not acceptable for white people to associate with black people. This demonstrated the Pentecostal significance of breaking down racial barriers and the ecumenical dynamics of early Pentecostals (Oluwole Olofinjana 2012). Early Pentecostal churches also emerged in Bournemouth, led by William Oliver Hutchinson in 1908, becoming the headquarters of a network of Pentecostal churches later known as the Apostolic Faith Church. Another early European

Pentecostal denomination was the Elim Pentecostal Church, which was founded in 1915 in Ireland by a Welshman, George Jeffreys (BBC 2009). However, the origins of Pentecostalism began in a very dynamic way in the USA.

1.8.1 History of Pentecostalism

Pentecostalism is an early-twentieth-century expression of Christianity, mostly associated with the work of African American William Seymour's Azusa Street Revival Movement. The Azusa Street Revival was a historic revival meeting that took place in Los Angeles, California, and is the origin of the Pentecostal movement (Corcoran 2011). It was led by William J. Seymour, an African American preacher and began with a meeting on April 9, 1906 which continued until 1915. The revival was characterised by spiritual experiences accompanied with testimonies of physical healing, miracles, worship services and speaking in tongues (Glossolalia), (Welchel 2013). Today, the revival is considered by historians to be the primary catalyst for the spread of Pentecostalism in the twentieth century. The intermingling of races and the encouragement of women in leadership was remarkable, as 1906 was the height of the 'Jim Crow' era of racial segregation and fourteen years prior to women receiving the vote in the USA (Allen 1994).

By the end of 1906, most leaders from Azusa Street had spun off to form other congregations, such as the Spanish Adventist Frontier Missions and the Italian Pentecostal Mission. Nearly all of these new churches were founded among immigrants and the poor (BBC 2009). Initially Pentecostalism flourished in individual churches across North America. Many existing Wesleyan-holiness denominations adopted the Pentecostal message, such as the Church of God in Christ, and the Pentecostal Holiness Church. The formation of new denominations also occurred,

motivated by doctrinal differences between Wesleyan Pentecostals and their Finished Work counterparts, such as the Assemblies of God, formed in 1914 and the Pentecostal Church of God, formed in 1919. An early doctrinal controversy led to a split between Trinitarian and Oneness Pentecostals; the latter founded the Pentecostal Assemblies of the World in 1916 (Synan 1997).

Generally speaking, Pentecostals believe that faith must be powerfully experiential, and not something found merely through ritual or thinking. Pentecostalism is energetic and dynamic. Its members believe they are driven by the power of God moving within them. Pentecostal churches stress the importance of conversions through Baptism in the Spirit. This fills the believer with the Holy Spirit, which gives the believer the strength to live a truly Christian life. The direct experience of God is revealed by gifts of the Spirit, such as speaking in tongues, prophecy and healing. Pentecostal Christians accept the status of The Bible as the indisputable and irrefutable Word of God (ibid).

(See Appendix 4 for Pentecostalism – Beliefs and Practices).

Today, Pentecostals are the fastest-growing group of Christians in the UK, according to research published by English Church Census (2006). Pentecostalism is not a church in itself, but a movement that includes many different churches. It is also a movement of renewal or revival within other denominations. It's not always easy to see if a church is Pentecostal because many Pentecostal denominations don't include the word 'Pentecostal' in their names.

What has been termed the 'The Windrush era' since 1948 has seen a surge of black Christianity in Britain, which has had a profound effect on British society, including the church. As well as establishing their own churches because of exclusion from British mainstream ones, migrants in the Windrush era travelled with their forms of Christian faith and practices, including Pentecostalism. Whilst those migrants belonging to mainline churches could easily find their churches, Pentecostals generally didn't find theirs and so started them in living rooms, school and church halls. The often-hostile reception to migrant members of British mainline churches from back home, ensured that many responded by joining the Pentecostal churches that were being initiated (Aldred 2016).

1.8.2 Growth of Pentecostalism in the UK

A range of factors have contributed to the growth of Pentecostal Christianity in the UK according to Clarke (2015), including the desire to maintain a sense of cultural identity in an unfamiliar and generally unwelcoming society. In addition to the rejection and discrimination they experienced, it drew people closer together. Church was a place of refuge and acceptance where spiritual, social, economic and emotional needs could be met (Charman 1979).

Many of the pastors included in Clarke's study saw themselves as pastors of the entire black community in their geographical areas, and increasingly pastors are emphasising the need for churches to be involved in the community. Many churches are trying to meet local needs by providing playgroups, luncheon clubs for senior people, or facilities for the unemployed. This is probably also contributing to growth, as people turn to the churches for practical help, or attend an activity organised by the church (Clarke 2015).

The overall picture is of an increasing number of growing and developing churches. Parsons (1993) estimated there are over 160 denominations involving perhaps 100,000 people in about 2,500 congregations. There are no indications that the growth is slowing. Britain's black-led churches appear to be in very good health and have much to teach other sections of the Christian Church (British Council of Churches 1976).

Pentecostalism is also changing the Christian landscape on a global level. In the West, Pentecostalism is strong in Black churches in America, and in Australian 'mega-churches' such as Hillsong Church. One of the world's largest churches is the Yoido Full Gospel (Pentecostal) Church in Seoul, South Korea, where up to 250,000 people attend each Sunday. There are just under one million Pentecostals in the UK, and over 20 million in the USA. The BBC series on Pentecostal Christianity (2006) suggests during the last three decades of the twentieth century Pentecostalism grew very strongly and there are now over 250 million Pentecostals around the world, which make up more than 10 per cent of all Christians. Other writers like Torres (2016) state that the Pentecostal church is considered one of the fastest-growing Christian churches in the world, with an estimated 500 million followers. The Pentecostal church is reportedly bringing renewed hope to many people in Britain as attested by its growing membership (ibid).

Alongside the increase in the numbers of black people attending BMCs in the UK, black people are represented in large numbers within the mental health system and this is discussed in the next section, together with black mental health.

1.9 Black Mental Health in the UK

People from African and African-Caribbean communities are more likely than others to be admitted to hospital for mental illness. The same is also true for people of white and black mixed ethnicity (Mental Health Foundation 2014). In addition to common everyday concerns such as money worries and work-related stress, African and African-Caribbean communities face further problems that can affect their mental health such as sub-standard housing, unemployment and racism.

Worldwide, people who move from one country to another have a higher risk of mental illness. This is especially true for black people who move to predominantly white countries, and the risk is even higher for their children. Therefore, mental illness is a larger problem for African and African-Caribbean communities living in the UK (Mental Health Foundation 2014).

African-Caribbean people living in the UK have lower rates of common mental disorders than other ethnic groups but are more likely to be diagnosed with severe mental illness. African-Caribbean people are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia. However, most of the research in this area has been based on service use statistics. Some research suggests that the actual numbers of African-Caribbean people with schizophrenia is much lower than originally thought (Mental Health Foundation 2014).

African-Caribbean people are also more likely to enter the mental health services via the courts or the police rather than from primary care, which is the main route to

treatment for most people. They are also more likely to be treated under a section of the Mental Health Act, are more likely to receive medication rather than be offered talking treatments such as psychotherapy and are over-represented in high- and medium-secure units and prisons. One reason suggested for this may be because they are reluctant to engage with services and so are much more ill when they do. Alternatively, it may be that services use more coercive approaches to treatment (ibid).

With regard to the role of the church in helping individuals with mental health distress, researchers at the University of Birmingham found that historically, churches have provided a range of help and support to individuals in mental distress, which is often undervalued and overlooked (Gilbert et.al. 2003).

1.10 Spiritual Care and Health

Miller (1999), discusses spiritual well-being as an important and too often overlooked dimension of health. Spiritual and religious involvement is not only common but is often important in clients' lives and has been generally linked to positive health outcomes. A client's spiritual perspective may be relevant in understanding his or her problems and useful in the process of treatment. Miller suggests that incorporating spiritual perspectives in secular treatment has been found to improve outcomes for religiously oriented clients. Govier (2000) provides an example of this in the development of a nursing model using the five dimensions of spiritual care, providing prompts in areas of reason reflection, religion, relationships and restoration.

In terms of how church membership can impact health, Miller suggests that a spiritual community can improve one's life, as many spiritual traditions encourage participation in a community. Spiritual fellowship, such as attending church, can be a source of social support, which may provide a sense of belonging, security, and community. Strong relationships have been proven to increase well-being and bolster life expectancy, which is perhaps why one study found a strong association between church attendance and improved health, mood, and well-being (VanderWeele 2017).

1.10.1 Impact of Religion on Health

A vast amount of research already exists with regard to the influence of religion on health, including mental health, conducted largely in the United States. Some examples include: Koenig (2009), a leading researcher in the field, who demonstrated that being religious results in more hope, optimism and life satisfaction, less depression and faster remission of depression (Koenig 2007; Smith, et.al. 2003); lower rates of suicide (Van Praag 2009); reduced prevalence of drug and alcohol abuse (Cook et.al. 1997) and reduced delinquency (Johnson et.al. 2000). Findings in relation to anxiety and religion are mixed; although some studies demonstrate reduced anxiety rates, others indicate that anxiety levels are heightened in the more religious (Koenig et.al. 2012; Shrieve et.al. 2004). Work on schizophrenia is still embryonic; recent studies in Switzerland suggest that religious individuals with psychotic illnesses frequently deploy prayers and Bible-reading to help them cope with their voices, and higher levels of religiosity may increase medication compliances (Mohr et.al. 2006).

The literature review in the next chapter will identify relevant British studies, further expanding on the themes mentioned in the introduction. It has already been

established that black people are part of British fabric and contributed to all factions of society throughout history. It has been demonstrated that wherever black people are located in the world, religious faith is central to much of their lives. This study focuses on Christianity, not only because it is more prevalent among black people in the UK, but also in acknowledgement of researcher bias. Christianity is a religion familiar to me as I am a member of a large multicultural, but predominantly black Christian church. I have a genuine interest in past and present developments, as well as the future of black Christianity in the UK. Further studies are discussed in the next section; the reader will note that literature cited is often older and/or fewer in quantity, directly reflecting the limited British material currently available in this area of research.

2. Literature Review

The literature review will present past and present research relevant to the project, with an emphasis on British contributions in the areas of race and health outcomes; religious faith and health, including mental health; perspectives on health and healing; race, religion and counselling; pastors'/leaders' influence on interpretation of problems and help-seeking behaviour and partnership working.

In order to give further context to the study we will explore the journey of black people from Africa to Britain and the role of Christianity as part of this process. A brief look at socio-economic data relating to black people living in the UK will then assist in providing an overview of their quality of life and implications for mental health and well-being; studies will be critically appraised on this basis.

2.1 Traditional African Religion

Mbiti (1989) offers valuable insight into African religion, highlighting that Africans are notoriously religious. Religion permeates all areas of life, he asserts, and it is difficult to isolate it. Mbiti estimates that there are about three thousand African people-groups (tribes) and each has its own religious system, beliefs and practices.

Traditional religions are not primarily for the individual, but for his/her community of which he/she is a part. In traditional society there are no non-religious people – to be human is to belong to the whole community and to do so involves participating in the beliefs, ceremonies rituals and festivals of that community. A person cannot detach himself or herself from the religion or his group, to do so is to be severed from his roots, his foundation, his context of security, his kinship and the entire group of those who make him aware of his own existence. Therefore, to be without religion amounts to self-excommunication from the entire life of society, and African people do not

know how to exist without religion. Through industrialisation, urbanisation and education individuals are moving away from the more traditional religion, but revert to old beliefs and practices in times of emergency and crisis (ibid).

According to traditional African religion there is a religious universe, nature is filled with religious significance, natural objects and phenomena are said to manifest or symbolise God and his presence. African people see the invisible universe when they see, hear or feel the visible, tangible world. The spiritual and physical dimensions are one and the same, and acts of worship of the spiritual take many forms depending on the particular society, including informal and formal, communal and individual, sacrifices and offerings of animals and foodstuffs and other items – ultimately to God but also to the spirits, who are the living dead seen as intermediaries between God and men, to whom prayers, invocations and salutations are offered. Other expressions of worship include incorporating God into children's names as well as singing, dancing and music (Mbiti 1989).

2.1.1 Africa and Christianity

Long before colonialism and slavery, Africans were practising Christianity one example is mentioned in the Bible in Acts 8: 26–40, when the Ethiopian eunuch converted to Christianity. According to Mbiti (1989), Christianity appears to have been introduced into North Africa before AD 180 because in July of that year the trial and execution of the first martyrs of the African Christian church took place, seven men and five women. The Moroccan explorer Ibn Battuta (1355) mentions Christians in Nubia (an area that covers present-day northern Sudan and southern Egypt) in his 14th century travelogue (Mamiya). But when Europeans penetrated Sub-Saharan Africa in the 16th Century, ultimately mining the region for Africans to enslave, the

historical narrative shifts, which is perhaps why many associate the religion mostly with Europeans. King-Hammond (2013) points out that once in America, many Africans faced a confusing range of options with respect to religion. While some slaveholders encouraged conversion to Christianity, others did not (Van Sertima 1986).

The history of Christianity in Africa is rich and complex with a number of significant figures and events which are worthwhile mentioning. Hilliard (1993), in his review of Frank Snowden's book *Blacks in Antiquity* (1970), notes limitations in the work, in as much as it is misleading and distorts the reality of black presence. Among the black antiquity Snowden failed to mention three black popes of Rome: St Victor I (189-199 AD), responsible for the observance of Easter on Sunday by both European and Asiatic Christians; St Miltiades (311–314 AD) during his reign the Roman Emperor Constantine converted to Christianity; St Gelasius I (492–496 A.D) born in Rome but of African parents, he introduced the Feast of Purification (Candlemas), composed many hymns and arranged a standard book for the Mass. Many artefacts of their faces were wiped out omitting their original African ancestry.

Black women too had a marked influence upon religious traditions of Europe. Redd (1979), in her essay illustrates how the Egyptian goddess Isis served as a prototype for the black Madonna of Europe. Isis was an African goddess whose worship eventually spread to most of the ancient Western world. The images of some early European goddesses, for example Sybil, Artemis which are represented as black, were directly borrowed to serve as representations of the Orthodox Christian Madonna (ibid).

According to Diop (1987), conclusive evidence erases any doubt that a thousand years before the Greek thinkers such as Socrates, Plato, Zeno, Egyptians with the reform of Amenophis IV, had clearly conceived the idea of a universal God responsible for creation whom all men, without distinction, could adore. He was not the God of any particular tribe, city or nation, but the God of all mankind. Diop suggests Christianity first appeared as a Jewish sect, but after Paul the Apostle was rejected by the Jews he turned to the 'pagans' to convert them, Christianity then became the religion for everyone as opposed to a given tribe chosen by God (Mbiti 1989). Christianity made no distinction between individuals and therefore appealed to those lower members of society who were now permitted to worship.

Mbiti (1989), states Christianity in Africa is so old that it can be rightly described as an indigenous, traditional and African religion. Long before the start of Islam in the seventh century, Christianity was well established all over North Africa, Egypt, parts of Sudan and Ethiopia. African Christianity made great contributions to Christendom through scholarship, participation in Church councils, defence of the Faith, movements like theology, translation and preservation of the Scriptures, martyrdom, the famous Catechetical School of Alexandria and liturgy.

Historical accounts claim John Mark, the apostle and evangelist, was an active missionary in Egypt and first established churches in the city of Alexandria (Mbiti 1989). The Egyptian church was fully established by AD 189 and several bishops were installed. Other notable events include Anthony, himself a young ruler who, after hearing the Biblical parable of the young ruler, sold his possessions and retired into the Sahara Desert, followed by many African Christians to live a life of possibly

the first hermits. Another Egyptian African founded the monastic life, Pachomius established the first Christian monastery on an island in the Nile.

A dynamic form of Christianity existed throughout North Africa, producing scholars and theologians such as Tertullian, Origen, Clement of Alexandria and Augustine. Tertullian was the first writer who made Latin the language of Christianity, two other key figures attributed with great honour for their contribution to Christianity and the African church are: Cyprian, who was a Bishop and martyr and Augustine, who wrote the confessions and is considered one of the most famous 'fathers of the church'. Emperors and empresses of Rome persecuted the church in Africa, which was later replaced with tolerance and acceptance of Christianity as the official religion during the reign of Constantine. Two hundred years later during the reign of Justinian and Theodora the state begins sponsoring missionary activity which was another term for imperial expansion.

Islam, paganism and political pressure eventually reduced African Christianity, surviving mainly in Ethiopia and Egypt. In these countries Christianity has kept its identity, particularly in Ethiopia, which for many centuries was cut off from constant contact with Christendom. This helped it, in part, to acquire a unique African expression but may have created difficulties with adjusting to modern times (Mibiti 1989). The Ethiopian Orthodox church is considered 'truly' African with little outside influence. Christianity survived in Ethiopia but Egypt could not resist Islamic invasion, along with other parts of North Africa. What remains of this Coptic Church is its long tradition going back to the apostolic times and strong belief that it was Mark who founded it. The Arabs conquered Egypt in the mid seventh century and Islam was established firmly in the land.

Roman Catholics from Portugal took up residence along the west, and east coast and the Congo estuary in the fifteenth century. As Denmark, Holland and Britain expanded their maritime, commercial and colonial activities, their clergy mainly catered for the increasing number of European traders with a fair number of Africans being converted.

The real modern expansion of Christianity in Africa started with freed Christian slaves who began to return to western Africa evangelising towards the end of the eighteenth century, and continued to increase greatly to the mid-nineteenth century, sometimes without any intervention from the clergy. The next phase saw an influx of missionaries from Britain, Europe and the United States around the same time as colonial occupation. Virtually every sect and denomination of Christianity in Europe, Britain and America has started its work in Africa. Hence, Africa does not have a single image of Christianity but several. Church structures and traditions imported from overseas, denominations and/or historic churches include Anglican, Roman Catholics, Lutherans, Baptists, Seventh-Day Adventists, Quakers, among others. Although African Christians worked very closely with missionaries to build mission churches, they soon separated due to the control that missionaries exercised over African converts and congregations. When Africans resisted European rule they were fined, imprisoned, deported or put to death. This over-dominance led many African Christians to seek local independence and sever ties with missionary-led churches. It was in the independent churches where Africans could be free and freedom was central (ibid).

2.1.2 African Presence in Europe

Van Sertima (1986), provides an extensive account in his book *Early African Presence in Europe*, detailing the migration and impact of black people to Europe as 'fathers of its inhabitants', the creators of its first art, first tools and during some historical periods its masters, teachers, invaders and traders, as well as its most acclaimed Madonna, saints and popes.

According to Greek history the first inhabitants were ancient African tribes, followed later by Egyptians and Phoenicians who brought names of gods and the alphabet respectively. Van Sertima (1986) asserts that racist scholars in the late-eighteenth century started the shift to reject the Ancient Model of Greek origins in favour of the more Aryan Model. But it is through theology and mythology that the most convincing evidence persists, refuting European superiority and clearly showing African sources of ideas and doctrines which were later heralded as the products of Greek genius (for example the existence of God, and many complex systems) for which Greek scholars and scientists were falsely credited with authorship, including Thale, Zeno, Plato and Aristotle.

2.1.3 The Nineteenth and Twentieth Centuries

Howard (1987), states that in the period leading up to the 1834 Act of Emancipation and immediately following it there was intense missionary activity which resulted in the growth of Methodist, Baptist, Moravian, Congregational and Presbyterian churches in the West Indies. The Methodists began their work in Antigua in the 1760s when a Methodist slave owner began to preach to his own slaves, and Baptist

work began in Jamaica in 1783 when a black Baptist preacher George Liele came from America to preach, establishing a chapel in Kingston. Non-conformist missionaries met with great opposition from whites. They were regarded with suspicion and hostility as friends of the slaves, and some were imprisoned on petty charges, such as infringing the terms of their licences. After emancipation, the Anglican Church opened its doors to freed slaves and they were encouraged to be baptised, married, confirmed and buried by the church.

Generally, the first half of the nineteenth century was a period of revival and growth for the West Indian churches. In the second half of the century and in the twentieth century, many other church groups and religious sects became active in the islands, such as the Salvation Army, Christian Scientists, Seventh-Day Adventists, Quakers and Jehovah's Witnesses.

Howard (1987), reports that several Pentecostal and Holiness churches were established as a result of links with groups in the United States. In 1909, a native of the Bahamas, Edmund Barr, visited a Church of God camp in Florida and returned home to evangelise. By the end of the second decade the Church of God had begun to grow in Jamaica (later known as the Church of God of Prophecy). By the end of the Second World War the Church of God had branches in nearly all the islands of the Caribbean. By 1960, it had grown to be the third-largest denomination in Jamaica, after the Baptists and Anglicans.

However, in some rural areas of certain islands cults and sects of African origin still persisted. Elements of African traditional religion had also been syncretised with elements of Christianity (usually Roman Catholic Christianity), for example, the

Shango cult of Trinidad, the Santeria cult in Cuba and the Pocomanian cult in Jamaica, which developed when surviving forms of African religion syncretised with revivalist Protestantism. Thus, the influences of different colonial powers, missionary activity and African traditional religion combine to produce an extremely varied and complex picture of religious life in the Caribbean (Turner 1984).

2.1.4 The Holiness Tradition

Howard (1987), points out churches in the Holiness tradition have their roots in American primitive Wesleyanism, which separated in 1843 from the Methodist Episcopal Church over the former's support for the abolition of slavery, the emancipation of women, and other political and social issues. The largest black-led church in the Holiness tradition in Britain is the Wesleyan Holiness Church. Other churches in the Holiness tradition in Britain include the A.M.E. (the African Methodist Episcopal) and various black-led Baptist churches.

2.1.5 Origins of Pentecostalism in the UK

Howard (1987), in exploring the roots of Pentecostalism, points out that Holiness groups believe the moral aspects of the law of God are pertinent for today, and so expect their members to adhere to certain rules, codes of conduct and behaviour sometimes based on biblical principles; others are more cultural expectations, for example, many groups have statements prohibiting the consumption of alcohol, participation in any form of gambling, and entertainments such as clubs. The Holiness Movement can be described as a protest against the perceived lukewarmness of some of the very churches – Methodists, Baptists, Quakers – that were themselves the result of dissatisfaction with and protest against Roman Catholicism in the Protestant Reformation. The late Swiss theologian Hollenweger (2005)

describes something akin to simultaneous combustion occurring when Pentecostalism sprang up, spreading dynamically in various parts of the world, including Britain.

Pentecostalism began expressing itself first among the Church of England and other established churches before evolving into churches such as Elim Pentecostal, Assemblies of God and the Apostolic Church since early 1900s. Elim (boasting some 550 churches in England and Ireland), a home-grown organisation, and the Assemblies of God (some 600 in the UK with a membership of nearly 70,000) being part of a wide global confederation of congregations (the largest of such in the world), and originating in the USA. These two Pentecostal denominations can claim to have some of the largest Christian congregations in Britain.

2.1.5.1 Pentecostal Beliefs in the UK

Regarding the theology of black-led churches Clarke (2015) highlights two temptations to avoid when exploring BMCs. One is to minimise the differences between the churches and the other is to over-emphasise them. Her study found that many people, including those within the African-Caribbean community, feel that BMCs are essentially all the same. Conversely, Gerloff (2004) identifies separate categories of black-led churches: churches are either in the Pentecostal or the Holiness tradition, and the Pentecostal churches either emphasise Jesus (the so-called Jesus Name or Oneness churches) or they emphasise the Trinity. Thus, three major categories emerge: Pentecostal Trinitarian, for example New Testament Church of God; Pentecostal Oneness, for example Oneness Apostolic; Holiness, for example Wesleyan Holiness. Almost all black-led churches hold a conservative

evangelical position and a fundamentalist view of Scripture. The terms 'Holiness', 'Trinitarian' and 'Oneness' are explained briefly below.

2.1.5.2 Trinitarian and Oneness

The word 'Trinitarian' is used to distinguish those Pentecostals holding an orthodox view of the Trinity from the Oneness or Jesus-Name Pentecostals. Trinitarianism is the belief in the three distinct persons of God, namely the Father, Son and Holy Spirit. The Oneness Pentecostals separated from the American Assemblies of God in 1913 over the form of words used at Baptism. They claim to go back to the earliest practice of the Apostles by baptising only in the Name of Jesus, rather than in the Name of the Father, the Son and the Holy Spirit. This practice reflects a different interpretation of Biblical verses from the doctrine of the Trinity. This idea developed from a 1913 sermon by R. E. McAlister (who had founded the first Canadian Pentecostal church). McAlister showed that in the book of the Acts of the Apostles and the Epistles baptism was always carried out only in the name of Jesus Christ and not using the Trinitarian formula given in Matthew 28:19:

Therefore go and make disciples of all nations, baptising them in the name of the Father and of the Son and of the Holy Spirit (KJV).

Others joined McAlister, and after close study of the Bible they came to the conclusion that Christ contained the totality of the Godhead and that baptism in the name of Jesus Christ alone was fully effective. They noted that when Jesus used the Trinitarian formula in Matthew 28:19 he used the singular word name rather than the plural names.

Frank J Ewart (one of the study group members) wrote:

In the four records of administering the rite of Christian baptism in the Book of Acts, we have the name Jesus mentioned in every one of them, but the words, Father, Son, and Holy Spirit are conspicuous by their absence.

The Scriptural justification, biblical texts that supported their views included:

For in Christ all the fullness of the Deity lives in bodily form Colossians 2:9

Peter replied, 'Repent and be baptised, every one of you, in the name of Jesus Christ for the forgiveness of your sins. And you will receive the gift of the Holy Spirit.' Acts 2:38

Salvation is found in no one else, for there is no other name under heaven given to men by which we must be saved. Acts 4:12

Membership of the Oneness churches totals approximately 17 million worldwide.

Oneness churches include: Bethel United Church of Jesus Christ Apostolic, United Pentecostal Church International (UPC), Church of our Lord Jesus Christ (COOLJC) and the Pentecostal Assemblies of the World (PAW) (Howard 1987).

Most Oneness or Jesus-Name churches have the word 'Apostolic' included in their title. Perhaps the best-known example of this is the Apostolic Church of Jesus Christ, which is an international (and the largest) denomination. Gerloff (2004), writes of the Oneness Pentecostals, that in Britain they form one-third of the black Pentecostal movement; one of the organisations, the Bethel United Church of Jesus Christ, is the largest indigenous black church in England, and they are more dynamic in both their interest for social change and ecumenical participation with other Christian bodies. Apostolic are the fastest-growing group among black Pentecostals (ibid).

2.1.5.3 Sabbatarianism

Sabbatarians observe the seventh day (Saturday) as the Sabbath (day of rest/worship). Observance of the Sabbath restricts day-to-day tasks, certain business and sporting activities. There are two main African-Caribbean Sabbatarian denominations, the Seventh-Day Baptists and the Church of God Seventh Day. Although one of the oldest non-conformist groups in England, alongside the Quakers in the seventeenth century, the Seventh-Day Baptist Church went into decline and is now non-existent in the UK. The Church of God Seventh Day encompasses both the Sabbatarian and Pentecostal traditions and hosts the greatest number of African-Caribbean Sabbatarian Christians. In fact, blacks now outnumber whites in what was once a predominantly white, middle-class church (Howard 1987).

2.1.5.4 Pentecostal Practices in the UK

Each Pentecostal church has its own unique emphasis, style and approach, but generally as a Christian denomination, Pentecostalism observes the usual practices and ordinances associated with Christianity, based on Biblical principles. They include: Communion, feet washing, baptism by immersions (only those at an age of accountability – babies are not baptised but christened or blessed), sharing testimonies (proof, demonstration of spiritual experiences and interventions) and preaching based on both Old and New Testament scriptures. Services are often much longer than in most white-led churches. Two-hour or even three-hour services are not unusual. Torres (2016), asserts that one of the things that draws people to Pentecostal and charismatic churches is the lively atmosphere inside these churches.

The worship experience in a BMC is characterised by exuberant worship, the preaching is dynamic and centred on meeting the social, religious and cultural needs of members. Although the liturgy is not written out by BMCs, there exists a formalised procedure amongst most of Britain's BMCs. This includes praise and worship, prayers, reading from the Bible, testimony, preaching, dancing and clapping. These features are indeed reflective of the fluidity of the African-Caribbean culture in the expression of the Christian faith (Howard 1987).

Preaching

Howard (1987) notes that until recently, commentary on contemporary social and political issues was rare, but this is changing and some preachers now address these themes. The sermon (or message) traditionally involves vocal responses from the congregation, such as 'Amen!' 'Hallelujah!' or 'Praise the Lord!', often encouraged by the speaker. This promotes active participation, unity and provides a form of emotional release and social interaction (as members are encouraged to repeat words and phrases to each other as directed by the speaker), and can signify agreement and even conviction. It is not uncommon for congregants to openly laugh or cry in response to the message. BMCs are speaking out on social and political issues, particularly racism and inner-city problems such as gang membership.

Most BMCs are actively validating African and Caribbean identity through their sermons and theologies, according to Akhazemea (2015). They help members build identity by focusing on the positive contributions of black people to and through the promotion of success-oriented theologies, which link faith and prayer with the expectation of material prosperity and success. Some BMCs also advocate for hard work and financial responsibility as necessary conditions for prosperity. For instance,

sociologist Stephen Hunt (2016) suggests that, in the case of the Redeemed Christian Church of God (RCCG), prosperity is more likely to be promoted in terms of 'management of monies', 'self-help' and 'entrepreneurial effort', rather than USA-style faith teaching.

Healing

Howard explains that much more emphasis is placed on healing in most black-led churches than in most white-led churches. Prayers for healing are often part of each service, and faith in God to heal any condition or sickness is central to the Pentecostal Christian's belief system. This will be significant when we explore interpretation of problems and help-seeking behaviours in section 2.6.5.2 (ibid).

Worship and Music

Music plays an important role in Pentecostal worship. Many churches have choirs, praise and worships teams and musicians. Howard (1987) observes that various musical styles are found, from traditional hymns (especially Moody and Sankey and Wesley hymns), to spirituals, traditional choruses and modern worship songs, often sung from memory. Many different musical instruments are used and worshippers often clap along with the singing. The atmosphere in a worship service in a black-led church is generally very warm and welcoming; it engenders a sense of social solidarity and acceptance (ibid).

Aldred (2016) adds further insight to Pentecostal worship, explaining that Pentecostal worship is less formal and more emotionally expressive than that of other Christian traditions. Participants worship with body, heart and soul, as well as with their minds.

Much Pentecostal worship is designed to engender an experience of God's presence and, to this end, the atmosphere, worship-leading and music encourage openness to the presence of the Holy Spirit. The gifts of the Spirit are often demonstrated during church services, sometimes dramatically, incorporating healings and speaking in tongues.

Aldred asserts that in Pentecostal churches there is a great deal of active congregational involvement; the worshippers may dance and clap. Preaching may rely more on stories and less on textual analysis. The congregation is likely to respond actively to the sermon with applause. The result may be that participants feel that the service is actually led by the Spirit. Consequently, Pentecostals are able to see the church as a community of God's people working to create the context for a direct experience of God. Some Pentecostals also use 'worship' to refer to their everyday life/lifestyle which they dedicate as a gift to God (ibid).

It is worth pausing here to consider Britain's long, rich and turbulent relationship with Christianity to the present day.

2.2 Overview of Christianity in Britain

(See Appendix 5: History of Christianity in Britain Timeline)

2.2.1 Status of Christianity in the UK

According to the 2011 Census the overall Christian decline in England and Wales relates particularly to white British Christians, whereas the number of black African

Christians grew by over 100 per cent. The British Social Attitudes survey from 1983 to 2014 charts a steady decline for the Church of England, a slight decline for Roman Catholics, and a substantial increase in 'Other Churches' in recent decades (which includes many BMCs) (Park et.al. 2014). In London, the number of white Christians declined by 18 per cent, whereas black Christian growth was 32 per cent over the same period (London Church Census 2011).

Regarding Religions in the UK, in the 2011 Census, Christianity leads with 59.5 per cent of the population, followed by Muslim at 4.4 per cent, Hindu 1.3 per cent and nonreligious 25.7 per cent. The number of white British identifying as Christian fell by 5.8 million between 2001 and 2011, whereas the number of British residents born outside the UK and identifying as Christian doubled from 843,000 to 1.6 million during the same period. Much of this can be attributed to the increase in migrants from EU countries. However, Christianity also rose among those identifying as African on the census, more than doubling from 330,000 to 691,000.

Research carried out by Brierley Consultancy provides insight into church membership in the UK between 2010–2015. The Faith Survey (2016) found UK membership has declined from 10.6 million in 1930 to 5.5 million in 2010 (that is, 30 per cent to 11.2 per cent). By 2013 this had declined to 10.3 per cent. Over the period 2005–2010 the main Christian denominations, such as Anglican, Catholic and Presbyterian all saw a decrease in membership. However, Orthodox, Pentecostal and other new churches (Evangelical and Charismatic) saw an increase. The survey also found church membership declining in all four countries of the UK, although England saw the smallest change whereas Scotland saw the largest decline. Results also showed church attendance has declined from 6,484,300 to 3,081,500 (that is

11.8 per cent to 5 per cent of the population), with England showing the lowest percentage population attending church in 2015 (4.7 per cent)

2.2.2 Decline of Christianity in Britain

Hill (2015) attempts to evaluate the impact of Liberalism on twenty-first-century Britain, and the erosion of beliefs and conduct in what was once regarded a Christian country. In 'The Spiritual State of the Nation' he suggests Britain is a tragic example of the overindulgence of goodness – the liberal assumption that human nature is essentially good. Since the 1960s the culture of Western civilisation has been dominated by an increasingly aggressive form of liberalism that worships tolerance but practices intolerance. The liberalism produced by the Enlightenment in the nineteenth century, he asserts, challenged the inequalities and injustices that pervaded urban industrial society and gained momentum through the work of eighteenth-century philosophers such as Rousseau. Modern liberalism has led to radical changes in the law and moral values of the nation. Hill believes it is liberalism that has led to the liberalisation of laws on abortion, divorce, gambling, drinking alcohol, the deregulation of financial markets, the removal of censorship on pornography and violence, all of which have changed the culture of the nation. On the positive side, he observes, liberalism has led the way in opposing racial and social prejudice and in measures, to promote equality. This reflects on Black churches is that they may be viewed as non-contemporary or as failing to move with the times, as they continue to hold conservative positions and are therefore considered outdated and out of touch with modern society.

2.2.3 UK Growth of Christian Pentecostalism

Akhazemea (2015) suggests that the growth of Britain's BMCs has been enhanced over the years by immigration as a result of the economic challenges of the African and Caribbean countries, war, famine and economic aspirations. However, some migrants are not economically motivated but rather feel they have a mandate to re-evangelise Britain, the country that was once the hub of the missionary enterprise to its former colonies in the mid-eighteenth and nineteenth centuries. Pentecostalism, perhaps more than any other manifestation of Christianity, has birthed numerous independent Pentecostal churches which have subsequently grown to become large denominations (Clarke 2015). Osgood (2012), identifies four church-planting 'waves' (establishing new churches) that led to the emergence and sustained growth of Pentecostal Christianity. Three 'waves' are associated directly or indirectly with the Pentecostal movement, which is generally regarded as having arisen through the emphasis on the baptism of the Spirit as evidenced by the gifts of the Spirit, which developed at the beginning of the twentieth century. The other is associated with the emphasis on the baptism of the Spirit and the availability of the gifts of the Spirit today, which marked the birth of the Charismatic movement in the mid-twentieth century. Neither of these movements was a strictly British phenomenon, as similar events were happening in the United States, either at the same time or occasionally slightly ahead.

2.2.4 Global Pentecostalism

Pentecostalism is particularly strong in the developing world where it poses a serious challenge to other, more established, denominations. Torres (2016), for example, reported Christians packing churches in India as Christianity sees surprising growth despite rising persecution. Writing for the Evangelical Fellowship of India, her report identified 134 separate incidents of violence committed against Christians within the

first six months of 2016. However, church leaders in India said they face a more significant challenge: how to train more pastors to sustain church growth.

Pentecostalism is particularly strong in South America, Africa, and Asia, with a unique character on each continent. Developing-world Pentecostalism has been particularly successful among the poor. Pentecostal denominations have grown particularly in Latin America among the largely unchurched and Roman Catholics and those at the bottom of the social and economic hierarchies. In this sense, Pentecostalism is a Christianity for the underclasses of the world (Conkin 1997). Pentecostalism's prosperity in the developing world is due in part to the energetic missionary work of Pentecostal churches and also to history, politics, flexibility and empowerment. Examples of these included emphasis on the interconnection of body, mind and spirit, which it displayed in its highly physical worship, in healing, speaking in tongues, and the acceptance of dreams and visions as valuable tools of spiritual insight (ibid).

2.2.5 Pentecostalism and Flexibility

Pentecostalism, more than any other form of Christianity, has a willingness to assimilate with local cultures; uses local music and other cultural elements in worship and values the teaching of the Christian message through religious ways of thinking and communicating that are already familiar to local people. Because Pentecostal worship is spontaneous and oral, rather than anchored in a liturgical text, submits Cox (2009), it allows all members of the congregation to play their part without any fear of doing the 'wrong thing' and enables each one to share their particular experience of God and have it valued by the whole community.

Additionally, the Pentecostal acceptance of the value of the body/mind/spirit connections resonates with the non-Christian spiritual background of many developing cultures and allows Pentecostal churches to incorporate without difficulty the elements of those cultures that are compatible with Christianity. The result is that Pentecostalism can take on a completely local costume.

2.2.6 Growth of Christian Pentecostalism in London

Black- and ethnic-minority Christians lead church growth in London, according to the London Church Census covering the period 2005 to 2012. The number of people attending church on a Sunday has leaped by 16 per cent, which means that a quarter of England's churchgoers are worshipping in London. The census, commissioned by London City Mission, found that two new London churches opened every week in the seven-year period and two-thirds of those were BMCs and a third catered for a particular language or ethnic group, such as Polish Lutheran or Ghanaian Seventh-Day Adventist.

While 300 existing churches in London closed in the seven years after 2005, some 1,000 new ones were started. Of these new churches, 93 per cent were still in existence after five years, against 76 per cent elsewhere. Growth is strongest in the parts of London that already have large churches or have significant African and/or Caribbean populations. Southwark, Lambeth and Newham saw at least a 25 per cent growth of new churches. Church attendance in these boroughs also grew over the same period, with Southwark and Lambeth seeing a 50 per cent growth and Newham growing by a third (Cooper 2013). According to an analysis conducted by Burgess (2016) for every Anglican church that has closed over the past six years, more than three Pentecostal or Charismatic churches have taken their place. Unlike the historic churches, the Pentecostal and Charismatic churches are drawing people of all ages

and races (Torres 2016).

The report claims that 720,000 people in London attend a Sunday church service, nearly 100,000 more than the last count seven years ago. The diverse congregations filling London's churches on a Sunday now represent a quarter of all English churchgoers, with 8.8 per cent of Londoners attending church each week (nearly 10 per cent in inner London) compared with 5.6 per cent of people in the rest of England. Nearly half of churchgoers in inner London (48 per cent) are black; nearly one in five (19 per cent) of black Londoners attends church each week. Two-thirds attend Pentecostal churches, though the black community is represented in every denomination.

According to an analysis by *The Times* of London, for every Anglican church that has closed over the past six years, more than three Pentecostal or charismatic churches have taken their place. Unlike the historic churches, the Pentecostal and charismatic churches are drawing people of all ages and races, including black, Asian and mixed-race people (ibid).

2.2.7 African Pentecostal Churches in London

Aldred (2016) continues to reflect on how Pentecostalism has changed over the years. In the 1960s and 1970s Black Pentecostal growth in Britain was mainly identifiable as Caribbean, but since the 1990s it is identifiably African, particularly Nigerian; some even refer to this as the 'Nigerianisation' of British Christianity. However, despite growth of African Pentecostal churches such as Kingsway International Church and Redeemed Christian Church of God, the historic white-led Pentecostals like Elim and Assemblies of God continue to thrive in Britain

and around the world, and are larger than any of the BMCs. Aldred reports that Pentecostalism in general constitutes a minority of Christians in Britain, and Black Pentecostalism in particular draws its support from a small percentage of British society that, according to the latest census, is fewer than five per cent of the overall population. Marked growth of Black Christianity was also identified in Leeds, Manchester and Birmingham. Researchers also found that other European cities have experienced striking BMC growth as well, for example, in the Netherlands and in Germany.

The London School of Economics (2016), 'Pentecostalism in Britain' series in collaboration with Africa, explores the place and role of religion in contemporary British society, and documents that African-initiated Pentecostal churches are on the rise in the United Kingdom, particularly in London (Hunt 2016).

Rogers (2016), in the 'Being Built Together' project, investigated the number, places and priorities of new BMCs in the London Borough of Southwark between 2011–13. The catalyst for this research was the rapid growth of BMCs in the borough over recent decades and the consequent shortage of suitable places of worship. In total 240 operational BMCs were identified in Southwark. The authors suspect this represents the greatest concentration of African Christianity in the world outside of Africa. Reasons given for such a dense concentration of African BMCs are that Southwark is considered the African capital of the UK; the centrality of Southwark in London also suits dispersed congregations and the availability and affordability of premises. Here Rogers examines how this relates to the broader picture of church growth and decline in the UK, and surmises that urban religious landscapes have changed dramatically over recent decades. This has important implications for public

policy, including planning policy and practice. Bremner (2016), found that of the eleven megachurches in the capital, six are Nigerian-led (or British-Nigerian).

Gerloff's (2004) study speaks of 'religions on the move', or the process of transmigration and transculturation, as it refers to dynamic, reciprocal, transitory and multidimensional creations in shaping a 'poly-contextual world'. The emphasis here is on a new model of understanding religion which emphasises process and practitioners over form and content (Yawney 2004).

Gerloff further identifies common elements of 'Africanness' that were not destroyed under colonialism and slavery, which function as vehicles of survival in crisis and marginalisation. They include the role of women, both in initiating and leading movements (hidden or public), who often become marginalised when these become institutionalised; the concept of Spirit, or the Holy Spirit, as a controlling and organising energy and principle, or as the One indivisible that unites people, power-in-participation, not just in church but in the world; the centrality of music and rhythms in the liberation of people and growth of assemblies, life-giving power, rhythms of creation, not least recognisable in Gospel music, but also in the overall influence of Black music on the modern popular scene; an understanding of the body-mind relationship in healing, dreams and visions as intuitive, interpersonal powers; the shaping of community identity, in which the individual functions as part of the whole organism; the potential for truth and reconciliation both from African philosophical and spiritual sources – one example being the concept of *ubuntu* in South Africa. This is close to the reality of *koinonia* in the New Testament – a person is never a person without other persons. She identifies a yearning among black youths in Europe for a relevant pan-African theology, drawn not only from intellectual

perceptions (such as pan-African philosophy), but also from artistic, cultural and spiritual sources, which may give rise to new biblical interpretations (ibid).

Pentecostalism offers attractive spiritual certainties in a world where religious truths are under attack, because a direct experience of God is unarguable to those who receive it: 'If it happens to you, you know it's true' (BBC 2009).

2.2.8 Pentecostalism in Britain Today

In summary, both migration and globalisation have enhanced Britain's religious and cultural diversity. Various labels have been utilised by scholars to describe this thriving strand within the British Christian landscape: black churches, minority ethnic churches, BMCs, Windrush churches, African-led, Caribbean-led churches and so on. These labels signify the level of diversity within this area of Christianity in the UK, and the complexity associated with having a general consensus on an adequate term to identify these churches (Akhazemea 2015).

Akhazemea asserts that one of the consequences of globalisation is the formation of immigrant communities. Most BMCs function as cultural oases where one could meet people with identical or similar ethno-cultural backgrounds. The churches remind congregants of their home countries and their native cultures. They are places where attendees can meet friends with similar life experiences. Among the many activities of the BMCs is their inevitable involvement with members' negotiation of socio-cultural identity in a new cultural frontier. These churches affirm the dignity of ethnic group members as well as providing support mechanisms to cope with associated

challenges of assimilation to the host country. This 'enabling environment' provides 'a home away from home' for Africans and Caribbeans in Britain.

2.2.9 BMCs' and Wider Socio-Political Issues

In a recent meeting between Baroness Amos and Black Church Leaders, Baroness Amos remarked pointedly, 'You don't seem to know how much political power you have.' As Robert Beckford (lecturer and author of *Jesus is Dread* 1998), points out, the Black Church in Britain needs to develop a political theology to accompany its emphasis upon mission and social engagement.

Politically and socially, Pentecostalism originated in churches filled with people who were poor and oppressed and it has never forgotten those roots. Its early leaders were working-class Christians with similar life experiences to the people they led. These factors give Pentecostalism great appeal in parts of the world where people continue to suffer poverty and injustice. Pentecostalism has a practical approach to the disadvantaged among them; churches work as 'mutual aid communities' to deal with poverty and sickness, and provide alternative solutions to problems that might otherwise be 'solved' through witchcraft or other superstitious practices (BBC 2009).

Clarke (2015) adds an important dimension to the discussion when she emphasises that during 1950s and 1960s black women were attending church in greater numbers than men (Calley 1962). Foster (1992), agrees that black women were the major contributors to the flourishing of the BMC in Britain, and were also major contributors to the historic mainline churches. Women were responsible for the teaching and organisation of Sunday School for children, nursery classes, day centres for the elderly and supplementary schools. They did the paperwork, administration,

organisation and catering for meetings and conventions (Toulis 1997). Women were often exhorters and evangelists and would lead worship. Women often were the ones who 'encouraged and prompt[ed] deeper worship and praise in order to experience the manifestation of the Spirit during services (Clarke 2015). Often described as 'Church Mothers', senior females were respected by younger congregants particularly females; the 'mothers' were often perceptive, supportive and encouraging.

According to Bremner (2016), there appears to be a holistic approach to meeting the spiritual, educational, social and economic aspirations of the communities where BMCs are present. Some of these interventions have been commended by political figures for their contributions to community development and cohesion. A typical example is the social engagement of Jesus House, which is in active collaboration with the Prince's Trust; Prince Charles commended their work during his 59th birthday celebrations at the church in November 2007. Ruach City Church received visits from various political figures including, Tony Blair (Donovan, 2006), Ed Milliband (Tiedmann 2013), Sadiq Khan, Diane Abbott and various local officials, celebrating its work around mental health and community initiatives.

Akhazemea (2015), goes on to say that BMCs not only serve as religious organisations but also are community networks that offer advice and help people access social services. Most BMCs provide a range of support and assistance to its members including: training on writing curricula vitae and wills, seminars on financial empowerment, immigration seminars, housing and educational initiatives, complementing the functions of statutory agencies. Above all, most BMCs provide access to social and spiritual resources for new migrants by providing contexts for

communal worship, prayer and Christian fellowship, thus contributing to the successful integration into wider society.

Akhazemea concludes that power evangelism, traditional evangelism, social actions and welfare are necessary tools of BMCs. It has been observed that Pentecostal denominations across the globe in the twenty-first century are not only identifying developmental challenges but are committed to the transformation of the social and political structures within their contexts. A typical example is the Redeemed Christian Church of God (RCCG), now a missionary player across the globe. It is evident in many RCCG churches that a lot of resources are being invested in human, social and intellectual development within the communities in which they are located. As important as spiritual development and proselyting are, there is the drive to contribute positively to the social well-being of the social fabric of local communities. This trend is evident in many BMCs like Kingsway International Christian Centre, Ruach City Church and a host of others who maintain a robust budget to cater for the needs of their communities. Projects that address the poor, drug addiction, educational empowerment, skills development, youth developments, mental health and related community initiatives demonstrate the involvement of BMCs within the communities in which they are located.

Overall, BMCs deliver numerous social and community initiatives run by members who volunteers their time and resources. Even though they are exposed to a whole range of challenging socio-economic factors themselves, which can affect health, well-being and overall quality of life.

2.3 Black People and Socio-economic Factors

The Office for National Statistics reported increasing ethnic diversity within England and Wales in the 2011 Census. Ethnic groupings in Britain showed 86 per cent white, mixed/multiple ethnic groups 2.2 per cent, Asian/Asian British 7.5 per cent, black/African/Caribbean/black British 3.3 per cent, other ethnic groups 1 per cent. London was found to be the most ethnically diverse area, while Wales was the least diverse. London had above-average proportions for most minority ethnic groups including African (7.0 per cent), Indian (6.6 per cent), and Caribbean (4.2 per cent). It also had the highest incidence of 'Any Other White' at 12.6 per cent. This raises the question of how racial groupings may help or hinder understanding of complexities within and between groups in relation to health. Ethnicity results from many aspects of difference, including social and political influences, race, culture, religion and nationality. People may identify themselves with more than one ethnic group, although to allow data to be collected and analysed on a large scale, ethnicity is often treated as a fixed characteristic.

2.3.1 Ethnicity, Ethnic Groupings in the UK

Ethnicity in the UK is mainly self-defined, through the ten-yearly UK population census. Ethnic groups are usually classified by the methods used in the census, which asks people to indicate to which one of sixteen ethnic groups they feel they belong. This immediately gives rise to a simplification of the true picture.

Given the diversity between and within African and African-Caribbean cultures, how useful is it to use the term 'black'? By putting these groups together there is a danger of important factors being overlooked and, at worst, not seen at all. Lowth (2015), states that understanding the ethnic mix of a population can improve healthcare

delivery by helping to focus resources such as screening programmes, education and resource allocation.

2.3.2 Race and Poverty

In the UK, around 40 per cent of people from ethnic minorities are in income poverty, twice the rate for white people. The income poverty rate varies substantially between ethnic groups: Bangladeshis (65 per cent), Pakistanis (55 per cent) and black Africans (45 per cent) have the highest rates, while Indians, black Caribbeans (30 per cent), Indians (25 per cent), white Other (25 per cent) and white British (20 per cent) have the lowest rates.

The overall conclusion is that approximately half of the 'excess' income poverty rates suffered by minority ethnic groups is due to differences in age structure, family type and family work status. The other half is correlated with extended families, family size, pay rates, the overall income distribution, as well as levels of unearned income, housing costs, the accessing of benefits and discrimination (Kenway and Palmer 2007).

2.3.3 Race and Education

The potential explanations put forward for the decline in the performance of black pupils, particularly black Caribbean pupils, and the widening of ethnic gaps, include the quality of schools attended by pupils from different ethnic groups (Cassen and Kingdon 2007), low teacher expectations of black pupils in English schools (Gillborn 2008b), and perceived low returns to educational qualifications in a prejudiced labour market (Kingdon and Cassen 2007). Cassen and Kingdon (2007) suggest that school

quality makes a difference to outcomes, even after taking into account students' social and economic circumstances. They argue furthermore, that disadvantaged students and minority ethnic students are likely to attend poorer-performing schools, which in turn affects their performance adversely. However, Strand (2010), cautions against uncritical interpretation of data from test results at Key Stage 2 as identifying poor-quality schools as the cause of black pupils' underachievement. His analysis of an entire English national cohort of over 500,000 pupils shows no evidence of significant differential school effectiveness in progress by ethnicity.

The 2002 OFSTED report on the achievement of African-Caribbean pupils, which involved the study of three successful primary schools in London and the Midlands, noted that third- and fourth-generation black Caribbean pupils in primary schools in England are not achieving the higher educational standards attained by the most successful pupils in UK schools. Black Caribbean pupils begin with high attainment, start to decline in Key Stage 2, tail off significantly in Key Stage 3 and are below that of most other ethnic groups at Key Stage 4. Black Caribbean pupils also appear to be in trouble at school more often than their non-black peers. Although rates of exclusion have declined in recent years, they are still over three times more likely to be excluded from school than the average for other groups.

2.3.4 Race and Health

Postnote (2007) is an office of both Houses of Parliament charged with providing independent analysis of public policy issues that have a basis in science and technology. On the subject of health and ethnicity, it focuses on health inequalities in the UK. Postnote describes health inequalities as differences in health status that are driven by inequalities in society. Health is shaped by many different factors, such

as lifestyle, material wealth, educational attainment, job security, housing conditions, psycho-social stress, discrimination and health services.

Regarding causes of ethnic inequalities, many ethnic groups experience higher rates of poverty than their white-British counterparts in terms of income, benefits-use, unemployment, lacking basic necessities and area deprivation (Platt 2002). There is a complex interplay of factors affecting ethnic health, such as the long-term impact of migration, racism, discrimination, poor delivery and take-up of health care, differences in culture and lifestyles and biological susceptibility (ibid).

Sir Donald Acheson's independent inquiry into Inequalities in Health (1998), was a key initiative that put health inequalities onto the policy agenda. The Acheson Inquiry made three recommendations for reducing socio-economic inequalities: policies and on reducing socio-economic inequalities should consider the needs of ethnic groups; services should be sensitive to the needs of ethnic groups and promote awareness of the health risks; and the needs of ethnic groups should be specifically considered in planning and providing health care.

Ethnic health inequalities have been demonstrated in large-scale surveys like the Health Survey for England, which show ethnic groups as a whole are more likely to report ill-health, and that ill-health among ethnic people starts at a younger age than in the white British. There is wider variation in the rates of some diseases by ethnicity than by other socio-economic factors (Bhopal 2007). The survey suggests some ethnic groups experience poorer health than others, for example, surveys commonly show that Pakistani, Bangladeshi and Black-Caribbean individuals report the poorest health, with Indian, East African, Asian and Black African people reporting the same

health as White British. Men born in the Caribbean are 50 per cent more likely to die of stroke than the general population, however, they have much lower mortality to coronary heart disease (Postnote 2007).

According to NHS Choices (2017), African and African-Caribbeans living in the UK are more likely than people from other cultures to have certain health conditions, including high blood pressure (hypertension), diabetes and prostate cancer. This is also the case for some mixed-race people of African or African-Caribbean descent. Experts are unsure why these conditions are more common in people of African and African-Caribbean origin, speculating that it may be linked to diet, lifestyle and different ways of storing fat in the body.

Physical health is intrinsically linked to mental health, of which diagnosis and treatment is often an area of contention; the next section explores this further.

2.4 Mental Health

The mental health charity Mind (2017) describes mental health as a state of mind, connected to feelings and thoughts and behaviour. Good mental health is when:

You care about yourself and you care for yourself. You love yourself, not hate yourself. You look after your physical health – eat well, sleep well, exercise and enjoy yourself. You see yourself as being a valuable person in your own right. You don't have to earn the right to exist. You exist, so you have the right to exist. You judge yourself on reasonable standards. You don't set yourself impossible goals, such as “I have to be perfect in everything I do”, and then punish yourself when you don't reach those goals.

According to Mind (2017) approximately one in four people in the UK will experience a mental health problem each year. In England, one in six people report experiencing a common mental health problem (such as anxiety and depression) in any given week. Although the overall number of people with mental health problems has not changed significantly in recent years, how people cope with mental health problems appears to be getting worse as the number of people who self-harm or have suicidal thoughts is increasing (McManus et.al. 2016). Reports from both England (NHS 2014) and Wales (Welsh Health Survey 2015) suggest that approximately one in eight adults with a mental health problem receive treatment. Medication was reported as the most common type of treatment for a mental health problem (Mind 2017).

2.4.1. The Cost of Mental Health in the UK

In 2015, research by Community Care and BBC News found that the funding for NHS trusts to provide mental health services had fallen by 8.25 per cent, £600 million from 2010/11 to 2014/15 (McNicholl 2015). Figures from the Health and Social Care Information Centre (2014), suggest that over a five-year period from 2008/09 to 2013/14 social care expenditure on adults with mental health needs aged between 18 and 64 reduced from £1.2 billion to £1.1 billion. Research found that 77 per cent of NHS clinical commissioning groups who responded (74 of 96) had frozen or cut their child and adolescent mental health services budgets (Young Minds 2014). The UK invests £115 million per year on mental health research mental health receives 5.5 per cent of the UK health research spend. Approximately £9.75 is spent on research per person affected by mental health problems (MQ –Transforming Mental Health 2015).

2.4.2 Mental Health and Gender

According to the charity Recovery Across Mental Health (RAMH) (2017), mental health problems affect women and men equally, but some are more common among women, with abuse being a major contributory factor to women's mental health problems. In England, women are more likely than men to have a common mental health problem (McManus et.al. 2016), and are almost twice as likely to be diagnosed with anxiety disorders (Martin-Merino et.al. 2009). Of people with phobias or OCD, about 60 per cent are female (The Office for National Statistics Psychiatric Morbidity report, 2001). In 2013, 6,233 suicides were recorded in the UK for people aged 15 and older. Of these, 78 per cent were male and 22 per cent were female (Bromley et.al. 2014). Ten per cent of mothers and 6 per cent of fathers in the UK have mental health problems at any given time (Parker et.al. 2008).

Women are more likely to have been treated for a mental health problem than men (29 per cent compared to 17 per cent). According RAMH this could be because, when asked, women are more likely to report symptoms of common mental health problems. Men are more likely than women to have an alcohol or drug problem. Sixty-seven per cent of British people who consume alcohol at 'hazardous' levels, and 80 per cent of those dependent on alcohol are male. Almost three-quarters of people dependent on cannabis and 69 per cent of those dependent on other illegal drugs are male (The Office for National Statistics Psychiatric Morbidity report 2001).

Ferguson's (2016) focus on black women and mental health, pertinent to the current study, asserts that mental illness is a stigma within the black community. Writing in *The Guardian* her article entitled 'The lowest of the stack: Why black women are struggling with mental health' suggests the perceptions of young black women in

everyday life may be exacerbating already high rates of depression and anxiety. In interviews with a number of young, black, professional women, their responses included:

'Why do I have to change who I am so that people don't find me intimidating or aggressive?'

'It's tiring to have to always conform to get ahead.'

'I can't embrace who I am, fully, I need to make sure people are always comfortable with me.'

'I have to prove that I can do the same thing as a white person, often what I say will be ignored, then someone who is not black will say it and all of a sudden it makes sense!'

'Being treated like I should be grateful for everything – because I am black and a female, the lowest of the stack. Therefore, anything positive I have achieved is not based on my academic or physical ability – but through help and compassion shown to me. I'm expected to be forever grateful; and, in return, be willing to be a slave to the man. White or black.'

The women admitted to 'playing a part' in order to get a job and be accepted while there. As a result, they feel they deliberately diminish what they perceive to be their 'black self' in order to progress (ibid).

In contrast, Breedvelt (2003) argues that little is known about black women and mental health, as they have been largely absent from research. She claims the majority of the research has looked at ethnic minorities as a whole, rather than providing a focus on the challenges faced by black women. The fact that black women face struggles with perception every day can often mean that the constant

fight seems normal, some women were resigned to the stereotype, *black women are scary, inadequate, ugly or hyper-sexualised* (Ferguson 2016).

Similarly, research devoted to black men and mental health problems are limited; researchers tend to use broad categories such as 'men', 'men from BAME communities' or 'black men'. Further studies sensitive to cultural differences between black men may yield interesting and useful results. Given black people – particularly black men – are over-represented in psychiatric services, this is an area requiring greater scrutiny.

2.4.3 Stigma

Rehman and Owen (2013), conducted a survey of 740 black and minority ethnic people experiencing mental health difficulties, including four groups of participants from African, Caribbean, Indian, and Pakistani/Bangladeshi backgrounds. The report focused on two distinct forms of discrimination: racial discrimination and discrimination because of mental ill health. Results show 93.2 per cent reported some form of discrimination; between half and two-thirds reported discrimination in finding or keeping a job, in housing or education and in forming relationships or having a family; just under half (49 per cent) said they experienced discrimination from mental health staff.

The authors concluded that even though there are some slight variations across ethnic groups, overall the consistent picture reveals that discrimination is everywhere. A third (32 per cent) reported experiencing either a moderate or significant discrimination from within their own communities because of their mental

ill-health. There is little variation across the groups, with Caribbeans at 33 per cent, Africans at 31 per cent, Indians at 36 per cent and Pakistanis/Bangladeshis at 29 per cent. Only a fifth of ethnic people feel able to speak to people about their mental health. As a consequence, 17 per cent felt unable to trust others. This impacts on self-confidence; only 16 per cent felt confident about their daily life and only 19 per cent about the future.

A significant study by Ineichen (1991), 'Schizophrenia in British Afro-Caribbeans: Two Debates Confused', draws attention to the considerable variations in rates of diagnosed cases between ethnic groups. British African-Caribbeans show high rates, at the same time, their psychiatric experience is marked by a high level of conflict with the psychiatric services.

2.4.3.1 Black Mental Health

Different ethnic groups have different rates and experiences of mental health problems, reflecting their different cultural and socio-economic contexts and access to culturally appropriate treatments (NHS Choices 2017). In general, people from black and minority ethnic groups living in the UK are: more likely to be diagnosed with mental health problems; more likely to be diagnosed and admitted to hospital; more likely to experience a poor outcome from treatment; more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health. These differences may be explained by a number of factors, including poverty and racism. Other explanations could be that mainstream mental health services often fail to understand or provide services that are acceptable and accessible to non-white British communities or that service providers fail to meet particular cultural or religious needs. It is likely that mental

health problems go unreported and untreated because people in some ethnic minority groups are reluctant to engage with mainstream health services. It is also likely that mental health problems are over-diagnosed in people whose first language is not English (ibid).

2.4.3.2 Black People and Statutory Mental Health Services

In her critique of a recent study, MacAttram (2017) draws attention to the dangers of research based on racist diagnostic assumptions. Her published response in *The Voice*, Britain's leading black newspaper, entitled: 'Why Are We Being Labelled?', strongly encourages critical analysis of any research making claims in relation to black mental health.

Black Mental Health UK (BMH UK) launched in 2006 at a church conference at KICC (Kingsway International Christian Centre), is devoted to addressing inequalities in the treatment and care of patients from African and Caribbean communities. BMH UK (2017), point out that The Mental Health Act is commonly viewed as a tool of state oppression against black Britons of African descent within the black community. It raises human rights concerns over the treatment of black Britons who are forced to use mental health services, not just over the coercive and punitive 'care' that they are disproportionately subjected to, but also the disproportionate use of long-term seclusion, as well as the routine attendance of police on locked psychiatric wards – often in riot gear – to 'assist' clinical staff in restraining patients, so that they can be forcibly medicated. Police use of Taser on locked wards and the absence of any statutory requirements for independent and public scrutiny of their use against patients, as well as the debilitating high doses of anti-psychotic medication that this

group are forced to take based on diagnoses that they are labelled with, are among key issues requiring urgent attention.

Marrington-Mir and Rimmer (2007), in their paper on 'Black and Minority Ethnic People and Mental Health in Britain: An Holistic Approach' challenge the medically dominated mental health orthodoxy in Britain and advocate for an integrated community development approach underpinned by anti-racist and empowering practices. It offers successful practice examples of a holistic, self-governed mental health system for black people in Britain. The paper draws on the philosophy of social action and Ubuntu, the African model of collective support, and argues for empowerment and participation. Together these influences form the basis of community development work in Britain and globally. The authors take issue with the 'championing' of the singular medical model, traced to the birth of psychiatry in England and North America in the mid-19th century, with critics evidencing recurring themes of oppression, control and intolerance of difference (Szasz 1977; Fernando 1995; Ndegwa and Olajide 2003). Coppock and Hopton (2000) remark on the continued notion of white maleness as the "norm" and 'supreme' in modern British psychiatry; their views and myths relating to race are key to early and current stereotyping of black people's behaviour in mental health and justice systems (Ndegwa and Olajide 2003).

Regarding these myths Fernando draws attention to the inability of some white psychiatrists to describe normal or abnormal emotions in black people, and their tendency to ascribe to black people the label of 'dangerous' or 'psychotic' where white patients would be diagnosed as 'depressed'. He argues that black people take a different route into services, are more likely to be in 'crisis' and are offered higher

dosages of psychotropic medication. He calls for a holistic assessment of people that takes into account their culture and their pathway to services (1988).

Marrington-Mir and Rimmer (2007), state that the daily experience of most black people in the United Kingdom involves having to cope from moment to moment with an environment that is antagonistic from the outset, permeated by unremitting racism. Or, as Blackman (2003: 3) puts it: 'being immersed in a racist society makes people mentally unwell.' Trivedi (2002: 71), adds: 'to oppress a race and then label its reaction as mental illness is not only morally wrong; it is criminal and a fraud.'

Copsey (2001) on behalf of The Sainsbury Centre for Mental Health's (SCMH) 'breaking the circle of fear' reveals how little confidence ethnic groups have in mental health services. So great is the fear of racism within services that users avoid them, leading to further deterioration and crisis point (SCMH 2002: 3). SCMH recommends that mainstream mental health systems should be replaced by a preventative, collective, community development service model, which includes a variety of disciplines and acknowledges the major theme of social action theory. This fundamental shift is highly dependent on 'expert' professionals and academics willingness to reflect upon their power base. The writers acknowledge the Government have responded positively to campaign groups, for example, by withdrawing the new Mental Health Bill with its controversial compulsory treatment orders in 2005 and 2006 and engaging user-led research, but much more needs to be done (Patel 2006).

Cochrane and Sashidharan (1995) point out Eurocentric bias is just as great in research on ethnicity and mental health as in the practice of psychiatry. There is a

long history of research comparing European and non-European behaviours and mental processes, which has often come to conclusions which now seem blatantly racist (Littlewood and Lipsedge 1982), but which were accepted as valid at the time. Although crude racist conclusions are no longer apparent in transcultural psychiatry research, implicit or subtle racism still pervades the discipline. This kind of research still tends to be undertaken by white people and to focus on areas where non-whites appear to have more problems. In their review of research on ethnicity and mental health, their findings reveal most of the research in this field has followed the conventional, epidemiological or medical paradigm by focusing on mental ill-health as the dependent variable and less empirically grounded research exists on mental well-being or the psychological resilience and survival of minority groups in this country (ibid).

2.4.3.3 Cultural Context

DeSilva et.al. (2015) define culture as systems of knowledge, concepts, rules and practices that are learned and transmitted across generations. Culture includes language, religion and spirituality, family structures, life-cycle stages, ceremonial rituals, and customs, as well as moral and legal systems. In the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013), DeSilva et.al. (2015) make a case for acknowledging cultural context (that is the cultural definition of the problem, cultural perceptions of cause, context, and support, including cultural identity and cultural factors that affect self-coping and past help-seeking,) when assessing patients experiencing mental health difficulties, who have migrated to the West.

2.4.3.4 Identity

Associated with culture and acculturation is identity. Mind reports that strong identity is a key feature of good mental health and rebuilding confidence. Marrington-Mir and Rimmer (2007) agree, stating a strong black identity is crucial to the restoration of good mental health.

Helm's (1995) Identity Models were introduced to assist in understanding the process of racial identity, using the term *ego status* to refer to the person as a whole (ego) and the statuses which most influence the person's action and words. Each ego status is comprised of attitude, thoughts, feelings and behaviour toward oneself, members of one's own racial group and towards members of other racial groups. 'The people of colour racial identity model' represents the ways in which black and minority individuals either adopt or abandon identities resulting from racial oppression' (Tuckwell 2002: 86–89). Helm argues the statuses develop sequentially and reflect increasing levels of racial complexity and sophistication within the individual with regard to understanding racial issues. While each status is present in the person, there is normally one predominant expression of one status according to the situation.

(See Appendix 6: Racial Identity Model: People of Colour Racial Identity Ego Statuses)

(See Appendix 7: Racial Identity Model: White Racial Identity Ego Statuses)

The People of Colour Racial Identity Statuses include:

Conformity status – External self-definition that implies devaluing of own group and allegiance to white standards of merit.

Dissonance status – Ambivalence and confusion concerning own socio-racial group commitment and ambivalent socioracial self-definition.

Immersion status – Idealisation of one's socio-racial group and denigration that which is perceived as white. Use of one group external standards to self-define.

Internalisation status – positive commitment to one's own socioracial group, internally defined racial attributes, and capacity to assess and responds objectively to members of the dominant group.

Integrative Awareness status – capacity to value one's own collective identities as well as empathise and collaborate with members of other oppressed groups.

Although one of many racial models, and originating from the United States, this tool may help in explaining how black people define and feel about themselves and indeed how they are made to see, and feel about, themselves. An important question is what happens to one's identity in the process of migration? Consequently, this has clinical implications when black people engage with establishments and services which treat them less favourably, and which echo the prevailing message: '*They are different, less-than, and not wanted.*' If this is then internalised, it is no wonder mental health difficulties and crises follow. Embracing one's own identity and being comfortable with, and in, one's skin, celebrating difference and uniqueness are key to good mental health. But what if the host nation makes this celebration and acceptance difficult for the individual?

2.4.3.5. Mental Health and Migration

It is estimated about five per cent of the world population is made up of migrants. Consequently, cultural assumptions are challenged and different behaviours and

potential psychopathologies emerge among all involved – migrants and hosts (Alarcón 2018). International agencies make clear distinctions between migrants proper, displaced people, and refugees. Migrants are those who decide to leave their country often dictated by occupational, professional, or financial factors. Displaced people are almost always forcefully ‘pushed out’ from their usual location, by violence (civil war, crime, terrorism, political upheaval), natural disasters, or social restlessness. Refugees are people who, having concluded that they are not compatible with the political regime, go through an established bureaucratic procedure to leave.

The World Mental Health Organisation examines the acculturation process, that is, the immigrant’s level of acceptability and adaptability of the host society’s habits and traditions is an important phase of the migratory experience. Social scientists speak of a fluid, mild or moderate, delayed or rejected acculturative phase – each one with potential implications of emotional stability or conflict. Occasionally, a ‘new’ culture or sub-culture evolves out of this process. The strength of the cultural legacy brought in by the immigrant and his or her family is a key factor that results in flexibility or rigidity, adaptation or alienation. Obviously, the host society’s receptivity and attitudes toward newcomers are another decisive factor, with outcomes of integration or rejection and their respective behavioural or clinical expressions.

Acculturative Stress or Acculturation Problem are diagnostic labels included in the current versions of DSM and ICD-10 (Classification of Mental and Behavioural Disorders Clinical Descriptions and Diagnostic Guidelines: World Health Organisation 2016). The author highlights that diagnostic issues have strong cultural implications when applied to migrant populations. A crucial topic is the validity of diagnostic

criteria used in the host country compared with the clinical pictures displayed by the newly arrived. Specific behavioural, symptomatic, or syndromic presentations (that is, cultural syndromes or cultural concepts of distress, according to DSM-5), must be carefully explored in order for clinicians not to fall into stereotyping or plainly stigmatising and labelling. Alarcón (2018) identifies PTSD as the most common psychopathology observed among migrants as well as depressive and anxiety-related disorders, in the context of 'situational' or 'adjustment' conditions. He refers to 'the causative pathogenic chain' as understandably feelings of loss, grief, panic, hopelessness, and helplessness is commonplace. He concludes a careful, comprehensive health assessment is vital in treating migrants in the psychiatric setting.

The fifth edition of the DSM was published in 2013 to a mixed reception. The British Psychological Society (BPS) published a largely critical response in which it attacked the whole concept of the DSM. It stated that a 'top-down' approach to mental health, where patients are made to 'fit' a diagnosis is not useful for the people who matter most – the patients. The UK mental health charity Mind took a more positive approach and believed for many people affected by a mental health problem, receiving a diagnosis enabled by diagnostic documents like the DSM-5 can be extremely beneficial, and it could give the person access to other support and services, including benefits. Clinicians from America made two main criticisms of DSM-5: an unhealthy influence of the pharmaceutical industry on the revision process and an increasing tendency to 'medicalise' patterns of behaviour and mood that are not considered to be particularly extreme (NHS Choices 2017).

2.5 Religion and Mental Health

The charity Rethink Mental Illness (2013) defines religion as being linked with a particular faith, tradition or institution. Religious beliefs may involve: a belief in a god, accepting some guidance or practices, restrictions on eating certain foods, expectation of praying and attending services on a particular day of the week. Some religious people describe themselves as spiritual rather than religious, while some spiritual people deny they are religious.

2.5.1 Religion and Spirituality

Rethink Mental Illness (2013) contends that spirituality and religion are not the same. Spirituality includes religion but it is more general and includes many other things. It can mean different things to different people. Spirituality can be shaped so it is unique and specific to the individual; one can also follow a common spiritual belief. Spiritual practices may include: belonging to a faith community, meditation for example mindfulness and prayer; living by a set of codes for example, in personal relationships with family and friends, or in the treatment of others generally and focusing on spiritual values such as honesty, kindness, hope and compassion.

Dein et.al. (2010), define religion as socially based beliefs and traditions, often associated with ritual and ceremony, whereas spirituality generally refers to a deep-seated individual sense of connection through which each person's life is experienced as contributing to a valued and greater 'whole', together with a sense of belonging and acceptance. Spirituality is expressed through art, poetry and myth, as well as religious practice. The writers suggest both religion and spirituality emphasise the depth of meaning and purpose in life. One does not have to be religious for life to be deeply meaningful, as atheists will maintain. Although some atheists might not

consider themselves spiritual, many do. Spirituality is thus a more inclusive concept than religion.

The Royal College of Psychiatrists' Special Interest Group on Spirituality (PSIGS) is committed to raising awareness around spirituality and mental health; studies have demonstrated spirituality may help your mental health. It may help to be part of a spiritual community and therefore have access to more support and friendship; feeling connected to something bigger than yourself as well as it helping to make sense of experiences also impacts mental health positively. Strength or hope can be gained from spirituality which may help during periods of ill health as well as giving a sense of peace (ibid).

The role of religion in maintaining good mental health and supporting mental health recovery has long been a contentious issue within Psychiatry and therapy in the West (Coyle and Lochner 2011). Larson et.al. (1994) reviewed Appendix C of the DSM-III-R (Diagnostic and Statistical Manual of Mental Disorders -3) Glossary of Technical Terms, for its references to religion. Larson et.al. observe that religion was referenced more frequently in this glossary than in psychiatric research, concluding that although the Glossary uses religion in constructive or cautionary reminders, the high rate of illustrative case examples of psychopathology that involve religion in the Glossary, indicates cultural insensitivity in interpreting religion. Similarly, Post (1992) observed the interpretation of religion in DSM-III-R which contained considerable negative bias and contributed to unfair stereotypes of religious persons. Particularly new religious movements and religious conversion were unfairly interpreted under the DSM-III-R heading, 'Dissociative Disorder Not Otherwise Specified'. He suggested that a more balanced and respectful interpretation of religion is needed in

DSM-III-R, since psychiatry should contribute neither to social intolerance nor to religious non-conformity.

Lukoff (2000) is co-author of the new diagnostic category 'Religious or Spiritual Problem' in the Diagnostic and Statistical Manual-IV (DSM-IV). He recalls that the mental health field has a heritage of 100 years of ignoring and pathologising spiritual experiences and religion. He cites Freud (1966), Fromm (1950) and Ellis (1980) and other founding fathers of western counselling/psychotherapy who have greatly influenced the perception of religion within the field, associating devout spirituality with psychopathology (Larson et.al.1993).

Dein et.al. (2010), in summary, observe in the past twenty years that there has been increasing attention given to the relationships between various dimensions of religiosity and mental health. Several thousand studies have been conducted demonstrating positive associations between the two (Koenig et.al. 2012). Furthermore, more altruism and gratitude in the religious have been cited as mediating factors in the links between religion and mental health (Schwartz 2003).

Nevertheless, claims that spirituality is beneficial for mental health have been criticised on the grounds that definitions of spirituality have been broadened so much that they imply mental health by definition (Koenig 2008). Spirituality traditionally had a narrow definition centred on belief in supernatural spirits such as God. However, mental health services have become increasingly interested in addressing the 'spiritual' needs of consumers in recent times, and as a result attempts have been made to redefine the term in a way that would be inclusive, so as to apply to people from diverse religious backgrounds and to those with no religion (Koenig 2008).

Many studies have broadened the term to incorporate a wide range of positive psychological concepts, such as purpose in life, hopefulness, social connectedness, peacefulness and well-being in general. This becomes problematic for research attempting to assess the relationship between 'spirituality' and mental health because by most definitions good mental health implies that a person has some purpose in life, is hopeful, socially connected and has peace and well-being. Thus, it becomes a meaningless repetition to insist that spirituality is associated with better mental health when the term is defined this way (Lindeman and Aarnio 2007).

McGreal (2013) comments on a British study that examined the relationship between spirituality and mental health involving in-depth interviews with over 7,000 people. Participants were sorted into those whose understanding of life was predominantly religious, spiritual, or neither. Participants were also interviewed in-depth about their mental health, alcohol and drug use, social support, use of psychotropic medication, gambling, and were asked about their overall happiness. Results demonstrated that religious participants were similar to non-religious/non-spiritual ones in regards to their mental health in most respects, although the religious were less likely to have used or been dependent on drugs in the last year. Spiritual (but not religious) people were more likely to take psychotropic medication, to use or be dependent on recreational drugs, to have a generalised anxiety disorder, phobia, or any neurotic disorder, or to have abnormal eating attitudes. These differences still held true even when considering factors such as social support and physical health, age, sex, and ethnicity. None of the groups differed in their overall happiness.

The authors conclude that people who are spiritual but not religious in their understanding of life are more vulnerable to common mental disorders than other

people. The nature of the causal relationship between spirituality and mental disorder is currently unclear. An earlier British study had similar findings and the authors noted that it is possible that not having a religious framework for one's beliefs could lead to mental disorder in people who have a need for a spiritual understanding of life (King et.al. 2006). Alternatively, having a mental disorder might prompt a person to engage in a spiritual quest in the hope of mental healing or deeper understanding of one's problems.

A study by Saucier and Skrzypińska (2006) considered the personality traits associated with 'spirituality' and religiosity. People who described themselves in conventional religious terms tended to be fairly conservative in their attitudes and beliefs. Those who were more spiritual and less religious tended to be more non-conformist and even peculiar in their outlook and personal traits. For example, they were more likely than other people to describe themselves as 'weird' and 'crazy'. Additionally, they tended to believe in a range of 'alternative' ideas such as psychokinesis, reincarnation, astrology, witchcraft, and psychic powers, say that they 'respect the power of magic,' and scored highly in measures of magical thinking, fantasy proneness, and self-absorption (Farias et. al. 2005). McGreal (2013), argues that characteristics such as magical thinking and so on have been linked to a set of traits known as 'schizotypy', or proneness to mildly psychotic thinking. Schizotypy refers to a cluster of cognitive, emotional, and behavioural traits that are similar to, but generally milder than those exhibited in schizophrenia. It is associated with unusual beliefs about reality (for example that it is possible to harm others by thinking negative thoughts about them) and the tendency to have odd perceptual experiences (such as feeling that strangers are reading one's mind). Other research has found that adherents of New-Age beliefs and practices (such as yoga, Reiki, astrology, and Tarot) tend to be high in schizotypy and this is reflected in a loose 'holistic' thinking

style (Farias et.al. 2005). Schizotypy tends to be associated with high levels of anxiety and depression (Lewandowski et.al. 2006).

A limitation of the study by King et.al. (2006) is that it did not examine the specific content of the beliefs and practices of the spiritual but not religious or why the three groups in the study did not differ in their overall happiness even though one group was more prone to mental disorder. McGreal concludes that with the increasing prominence in modern society of people who consider themselves spiritual but not religious, more in-depth research is needed to understand fully why this group seems to be particularly vulnerable to mental illness.

Persaud et.al. (2017) in 'Research in Religion, Spirituality and Health and its Clinical Implications' assert that the discipline of psychiatry must be hyper-aware of, and sensitive to, religion as an aid in the treatment of mental illness. Careif, a Scottish mental health charity, strongly supports the incorporation of religion and spirituality into mental health care, thereby emphasising the bio-psycho- socio-spiritual model.

2.5.2 Religion and Psychiatry

Although not a British writer, American researcher Koenig (2008) is one of the leading authorities in the field and holds similar views. He writes that religious beliefs and practices of patients have long been thought to have a pathological basis, and psychiatrists for over a century have understood them in this light. Recent research, however, has uncovered findings which suggest that, to some patients, religion may also be a resource that helps them to cope with the stress of their illness or with difficult life circumstances. What are psychiatrists doing with this new information?

How is it affecting their clinical practices? asks Koenig. Studies of psychiatrists in the UK, Canada and the USA suggest that there remains widespread prejudice against religion and little integration of it into the assessment or care of patients. Koenig discusses a range of interventions that psychiatrists should consider when treating patients, including taking a spiritual history, supporting healthy religious beliefs, challenging unhealthy beliefs, praying with patients (in highly selected cases) and consultation with, referral to, or joint therapy with trained clergy (Koenig, 2007). Religion is an important psychological and social factor that may serve either as a powerful resource for healing or be intricately intertwined with psychopathology (ibid).

In a response to Koenig's editorial in the above *Psychiatric Bulletin*, Dein et.al. (2010) point out some difficulties professionals face in implementing some of his recommendations in relation to spirituality and religion in the workplace. Some professionals view taking a spiritual history as potentially 'intrusive', believing spiritual and religious concerns go beyond the brief of the psychiatrist, and seeing prayer as a 'non-clinical' activity that blurs boundaries and creates ambiguity (Poole et.al. 2008). It has been argued that the practices recommended by Koenig are not evidence-based (Lepping 2008). Concerns have also been raised about the place of religion in delusional systems, and that religious physicians may be less likely to seek psychiatric help for their patients (Mushtaq and Hafeez 2008).

Dein et.al. (2010), maintain that these kinds of concerns have reinforced some service users' perceptions of hostility within psychiatry towards spirituality and religion. However, they also suggest that there is need for further debate about the research evidence, ethical boundaries and the professional practices that govern the relationship between spirituality and psychiatry. PSIGS advocates that psychiatrists

should respect their patients' religious and spiritual beliefs, and that these beliefs should be given thoughtful and serious consideration in the clinical setting. It suggests it is time to move away from the old tendency to see religious and spiritual experience as pathology and towards an appreciation of how religion and spirituality can be conducive to mental health. This may be a difficult problem to resolve as most psychiatrists are less religious than their patients and neglect religious issues in clinical assessment. Consequently, individuals with religious beliefs may be extremely reluctant to engage with psychiatric services that they perceive to be nonreligious, scientific and disparaging of religion. This clearly has implications for black people who are more likely to be religious and arrive within the system in crisis. Consequently, every psychiatric assessment should not simply be a collation of symptoms but an enquiry into the meaning of those symptoms.

Taking a spiritual history is, therefore, important in understanding an individual's coping strategies, as well as identifying the potential for conflict with recommended treatments (PSIGS). The authors recognise how to engage religious groups in mainstream psychiatric services, and the problems that religious individuals encounter during assessment and treatment requires further research. The use of 'culture brokers' (key representatives of cultural groups) to mediate between religious communities and mental health services is also under-researched (Dein et.al. 2010). It is also worth mentioning the developing area of transcultural psychiatry which takes account of social and cultural factors that influence the origin, course and treatment of psychiatric disorders.

2.5.2.1 Spiritual Care

Greasely et.al. (2000), observe that despite many articles addressing the issue, spiritual care remains poorly understood. Similarly, Coyte (2011) notes that the importance of spirituality is increasing in clinical practice and in research in psychiatry. Consequently, this raises questions about the boundaries of good professional practice. With increasing evidence for spirituality and religious coping as important tools for dealing with mental health issues, she suggests psychiatry be more attentive to the ways in which people find meaning in spirituality and religion. Inevitably this requires that more clinical attention be routinely given to spiritual history-taking, incorporating this into treatment planning.

Cook et.al. (2009), suggest the most common and effective method of assessing spiritual needs when taking a history involves engaging with people as equals in enquiry and discussion, using their own words. White (2006) concurs, stating that part of health care processes should include creating opportunities that allow deeper conversations about meaning and purpose. Earlier, Narayanasamy (2001) developed a hierarchy of questions regarding religious and spiritual practice. Moving from general to specific, the categories include: meaning and purpose, source of hope and strength, love and relatedness, self-esteem, fear and anxiety, anger, relationship between spiritual beliefs and health, concept of God/deity and spiritual practice.

McSherry (2001), argues that no single professional group can be totally responsible for provision of spiritual care. Several NHS Trusts have already developed their own spiritual care strategies, for example Egger (2001), co-author of Engaging Spirituality: NIMHE Spirituality and Mental Health Project, set up a working group within her Trust to serve as a template for setting out minimum standards: statement

of intention on faith and spirituality to be adopted by Trust; faith, belief and spiritual assessment form; multi-faith chaplaincy. Trusts such as East London Foundation Trust, Sussex Partnership NHS Trust, Birmingham and Solihull, Bradford, Kent and others have all developed spiritual care strategies. Greasley et.al. (2000), suggest a more holistic approach should be adopted throughout healthcare, involving multi-interdisciplinary education in spiritual care.

2.5.3 The Positive Impact of Religion on Mental Health

Cornah (2006) writing for The Mental Health Foundation (2014), conducted a systematic literature review of the positive contribution spirituality can make to mental health. Using accounts from service users and survivors, the author also identified ways in which spiritual activity can contribute to mental health, well-being mental illness and recovery. With depression being the most common mental-health problem in the UK, it has been the subject of much research exploring the relationship between spirituality and mental health. Evidence reveals a positive association between church attendance and lower levels of depression amongst adults, young people and children (Olszewski 1994); reduction in depressive symptoms is associated with belief in a higher being as well restoring meaning, purpose and hope. Similar patterns emerge in relation to stress and anxiety. Quantitative research reveal reduced levels of anxiety in a number of populations including medical patients in later life (Koenig et.al.1988), women with breast cancer (Baider and Sarell 1983), middle-aged people with cardiac problems (Ai et.al. 2004) and those recovering from spinal injury (Hodges et.al. 2002). Qualitative studies also demonstrate that non-religious spiritual practices such as yoga and meditation improve mental health and reduce levels of anxiety.

Studies are emerging with regard to the association between religion and post-traumatic stress disorder (PTSD). A review of eleven studies reported three key findings: firstly, that religion and spirituality are beneficial in the aftermath of trauma; secondly, that traumatic experience can lead to a deepening of religious faith or spirituality; and third, that positive religious coping, religious openness, readiness to face existential questions, religious participation and intrinsic religiousness are all associated with improved post-traumatic recovery (Shaw et.al. 2005).

Notwithstanding, Cornah acknowledges the evidence is not without its limitations and her review identifies some major criticisms. An over-reliance on quantitative studies that look for a simplistic, linear relationship between discrete variables also tends to operationalise spirituality solely in Judeo-Christian terms. This leads to biases in the participants involved in the research and makes assumptions that may be irrelevant or offensive to individuals whose spirituality finds expression in other ways. One particular failing within the research is the assumption that the effects of spirituality on mental health are entirely explainable through psychological or social mechanisms. An emerging group of researchers are exploring ways to measure the so-called 'non-empirical' dimension of spirituality.

Quantitative measures may not fully access the meaning spiritual activity has for the individual and tends to try and isolate the impact of one activity (for example church attendance) upon another (for example level of depression), which may not always capture the rich and complex interactions of other factors on any association found. The over-reliance upon self-report measures may also exclude certain groups for whom spirituality is important but who may not articulate that through written measures, such as those with learning disabilities (Hatton et.al. 2004), people for

whom English is not a first language or those who cannot or do not want to reduce their spirituality to a series of items on a questionnaire (ibid).

Qualitative research describes the way in which religious and spiritual experiences of service users are pathologised, ignored or dismissed by many working in mental health services (Nicholls 2002). Psychiatry is accused of being prejudiced against spirituality (Turbott 2004), owing to assumptions that it is not an area which is deemed credible in terms of research. Swinton (2001: 42) points out psychiatrists themselves recognise that it is hard to discuss issues of spirituality and religion with colleagues because they 'cannot be accommodated within the model of mind on which so much of psychiatry is founded.'

Comah (2006), draws attention to the fact that evidence exploring spirituality with schizophrenia is relatively scarce. But in one review of the literature, evidence demonstrates that religion plays a central role in the processes of reconstructing a sense of self and recovery in relation to schizophrenia. Another study found that, for individuals who share the same religious values as their family, religiosity can be a cohesive and supporting factor. Others have found that people with a diagnosis of schizophrenia find hope, meaning and comfort in spiritual beliefs and practices.

2.5.3.1 The Negative Impact of Religion on Mental Health

Rettner (2015), however, suggests religion could also be a double-edged sword. A person's negative religious beliefs, for example, that God is punishing or has abandoned him or her, have been linked with harmful outcomes, including higher rates of depression and lower quality of life. If people have a loving, kind perception

of God and feel God is supportive, they seem to experience benefits. However, (Pargament, 2013) a professor of psychology and an expert in religion and health suggests there is a darker side to spirituality – if God is perceived as punitive, threatening or unreliable, then that negatively impacts health.

Of the thousands of studies that exist, the majority have been cross-sectional, focusing on religious attendance and beliefs among North American Christians. Much less is available in areas such as ritual, prayer and other aspects of being religious observe Dein and Littlewood (2007); Dein (2010). Although studies involving Christianity are more dominant, studies on other religions are emerging such as Islam (Abu-Rayya and Khalil 2009), Judaism (Rosmarin et.al. 2009) and Hinduism (Tarakeshwar et.al. 2003).

In addition, Dein et.al. (2010), identify areas where religion may have a damaging effect on mental health. Identifying data from several sources, they found religion can negatively impact on health through inducing guilt and dependency and in extreme cases may precipitate suicide, for example in extreme cultic groups (Dein and Littlewood 2005). Sloan et.al. (1999), however, point out there may be selection biases when recruiting subjects and that more work needs to be done on the non-religious and their mental health associations, including atheism and agnosticism (Hwang et.al. 2009). Areas requiring further research are: similarities and differences between religion and spirituality, cultural factors with regard to beliefs and practices (Milstein et.al. 2010), and more theologically sensitive measurement scales (Dein et.al. 2012).

Some published work is also available on hearing God's voice. In a study of forty English (white) Pentecostal Christians in London who completed a questionnaire on prayer, twenty-five reported an answering God's voice, with fifteen hearing Him audibly. The latter groups were interviewed and characteristics of phenomenology and context elicited. Often accounts of hearing the voice of God are pathologised, but many report the positive impact in situations of doubt or difficulty (Dein and Littlewood 2007). One wonders if a similar outcome would have been reached had the participants been black. Dein et.al. (2010) emphasise the need for a meaning-centred approach in British Psychiatry which is central to recovery. For example, it is not enough to ask about voices, what is more important is how hearing voices influence a person's life, how the individual makes sense of the experience and how might they best cope with the voices?

Some researchers have examined religious delusions within mental health presentations although this area is under-researched. A delusion is a false, unshakeable idea or belief which is out of keeping with the patient's educational, cultural and social background; it is held with extraordinary conviction and subjective certainty, it is a phenomenon outside normal experience (Sims 2003). Delusions are generally classified according to their content; religious delusions are just one of many, these delusions are held without insight. So, what is the difference between delusion and faith? Those with religious beliefs accept that some of their phrases are not to be taken literally for example *I gave my heart to the Lord Jesus*, in some mental illnesses abnormal thinking processes result in concrete thinking (Sims 2012).

Siddle et.al. (2002), in a cross-sectional study, investigated religious delusions in patients admitted to hospital with schizophrenia. Religious delusions are clinically

important because they may be associated with self-harm and poorer outcomes from treatment. The authors assert rates of religious delusions in schizophrenia in the UK remain high and have an impact upon an individual's health belief model (Kelly et.al. 1987) and therefore, their adherence to treatment. The authors make reference to a number of high-profile cases in which patients with what would appear to be religious delusions, have acted upon these delusions with fatal consequences. Although such incidences are rare, religious delusions are of clinical significance for two reasons: in case studies, religiously deluded people took biblical verses which involved acting them out (Blackner and Wong 1963; Field and Waldfogel 1995; Kushner 1967; Waugh 1986) and poorer outcomes from treatment (McCabe et.al.1972; Thara and Eaton 1996; Doering et.al. 1998). The reasons for these consequences of religious delusions are unknown and clinicians are unclear as to the best way to manage manifestations. There have been few dedicated scientific investigations of religious delusions in schizophrenia (Siddle et.al. 2002).

The content of delusions has been shown to vary between populations and over time (Ndeti and Vadhwa 1984; Kent and Wahass 1996; Al-Issa 1995). Siddle et.al. (2002) argue that to some extent there should be no surprise that people with schizophrenia exhibit a religious element to their delusions, since the majority of people, even in the UK, are reared within a culture where religious belief to some degree is the norm. Harrow et.al. (1988) suggest delusional ideas are on a continuum with normal beliefs, and normal religious beliefs are held in many cases as overvalued ideas, somewhere between delusions and 'normal beliefs' (Jackson 1991; Strauss 1991; Jones and Watson 1997; Peters et.al. 1999). It seems likely that many religiously deluded patients will have shifted along the continuum from the 'normal' but overvalued religious ideas eventually to religious delusions.

Regarding psychotic experiences (psychosis – when the individual perceives or interprets reality in a very different way from people around them that is, having 'lost touch' with reality), Siddle et.al. suggest the most common types are: hallucinations, delusions, disorganised thinking and speech. Studies suggest religious people in particular are more likely to make sense of their psychotic experiences by developing religious delusions, which in turn may help to deal with the negative life events that they are faced with. Since religious delusional explanations should be anticipated in any culture where religion is present, it is reasonable to expect a higher rate of religious delusions. This has been shown with seven per cent in Japanese patients, 21 per cent in Germans (Tateyama et.al. 1993) up to 80 per cent in African-Caribbean populations (Kiev 1963). The authors admit that failings with the studies include the differences in definition of religious delusion, which may affect the prevalence rates, and note that in many of the studies the actual definition of what was considered a religious delusion was not outlined.

Carroll (2013) points out that it is just as short-sighted to view unusual experiences as being psychotic as it is to view every symptom of mental illness as a sign of spiritual evolution. There are many genuine cases of mental illness which call for psychiatric treatment and for which medication might offer great benefit.

The charity Rethink Mental Illness (2013), maintains spirituality may improve mental health although researchers are not totally sure why. However, they suggest some religious beliefs may not be helpful for the unwell. Religious beliefs may lead individuals to feel guilty or in need of forgiveness; this may impact on their mental health. Some religions may claim that people with mental illness are possessed by demons or spirits. Others posit that someone has a mental illness because of wrong-

doing; these beliefs might prevent people from getting professional help. Religious groups may suggest different solutions to help the afflicted person, such as exorcisms, herbal remedies or witchcraft. These approaches may be more harmful than helpful. Rethink warns that if a person is vulnerable, members of faith communities may try to exploit them, as the person may be susceptible to people who want to impose their views onto them. People feel more vulnerable in times of difficulty and emotional distress; extreme religious groups may look for vulnerable people and draw them into their cult or group. Cults may persuade people to follow their practices and their set ways of thinking. People who are isolated or lonely may be more vulnerable to this type of situation.

Obeah is described as traditional witchcraft, sorcery or shamanism brought by enslaved Africans to the Caribbean, it is practiced particularly in Jamaica and includes traditional healing practices and a belief in magic and is generally not endorsed by Christians. Ellis (2015) conducted a significant study and argues psychiatric conditions relating to the Jamaican belief in 'Obeah' are specific, culturally interpreted phenomena that psychiatric nurses may encounter among Jamaican patients. In her paper she describes the phenomenon of Obeah and its influences on the worldview of life, health, illness; psychiatric conditions in the form of culture-bound syndromes and help-seeking behaviours throughout Jamaican cultural communities. Her conclusion highlights that in order to provide culturally authentic healthcare, psychiatric/mental health nurses and other professionals must familiarise themselves with the culture-specific syndromes, idioms of distress, beliefs and practices that may present among the diverse patient groups with whom they work. In her opinion, inability to understand the Obeah-illness concept from a culturally interpreted perspective may be constrictive and result in less-than-optimal care.

Amid historical, political, socio-economic, psycho- bio-spiritual challenges, health and mental health inequalities, stigma, discrimination and disadvantage, abuse and trauma through enslavement and colonialism in the name of Christianity, what role does faith and a church community play in the life of the black Christian? It appears Christian faith is stronger than ever, signified by continued growth of BMCs. Despite experiencing the struggles mentioned above, black Christians and BMCs are thriving and remain dedicated to helping the disadvantaged within their communities. This level of resilience, resourcefulness and robustness is surely worth examining, and represents something black Christians may be able to teach other about maintaining good mental health in spite of difficult life circumstances and events. The following section will explore religious coping, faith and role of the church community in sustaining health and well-being.

2.6 Coping Strategies

Coping strategies refer to specific efforts, both behavioural and psychological employed to master, tolerate, reduce or minimise stressful events (Taylor, 1998). During times of emotional difficulty, individuals resort to a range of mechanisms examined below.

2.6.1 Therapy

The British Association for Counselling and Psychotherapy (BACP), describes therapy as a term which covers talking therapies, such as counselling, psychotherapy and coaching. Therapy offers a safe, confidential place to talk to a trained professional about feelings and concerns. A person might talk about difficult life

events or relationships and emotions. Or there might be negative thoughts and behaviours a person wants to change.

Therapists will not give advice or solve a person's problems. They will listen, and help individuals understand themselves better and make positive changes in their life. The BACP emphasises, 'your relationship with your therapist is very important. To get the best out of the process it's important that you have confidence in them. Trust your instinct and if you're unsure about the therapist, seek another one.'

2.6.1.1 Therapy and Race

'We Still Need To Talk,' a report on access to talking therapies (2014), was produced by the We need to talk coalition, comprising leading mental health charities and mental health organisations in the UK. The coalition reported people from BME communities have long been under-served in primary mental health services and are much less likely than other groups to be referred to psychological therapies. In the NHS (1999) A National Service Framework for Mental Health stated BME communities face significant barriers to accessing psychological therapies as often many local areas lack culturally sensitive and tailored services which meet the diverse needs of the local population. Secondly, people from BME communities often first come into contact with mental health services at the acute stage of their condition due to a range of issues, from stigma and discrimination in the NHS to cultural attitudes within communities which prevent people seeking help.

Zahid (2017), in her compelling paper about the black experience in mental health services, states clearly mainstream mental health services are failing to understand

and/or provide services that are acceptable and accessible to black and ethnic minority communities and cannot meet their cultural needs. These differences can be explained by factors such as poverty and institutional racism. She highlights that mainstream approaches to counselling and psychotherapy might be so bound up by European assumptions about human nature, that they become irrelevant to people from non-European cultures. She goes on, perhaps the influence of slavery, colonialism, and oppression on the development of psychotherapy has been underplayed within the therapy world, considering it evolved during the late 19th century when racism was the norm. For example, racist attitudes were not easily changed after the Abolition of Slavery Act was passed in 1833 and, even amongst the well-educated, these ignorant beliefs were difficult to abolish, as reflected in the following quote by Charles Darwin:

'At some future period, not very distant as measured by centuries, the civilised races of man will almost certainly exterminate, and replace the savage races throughout the world. At the same time the anthropomorphous apes... will no doubt be exterminated. The break between man and his nearest allies will then be wider, for it will intervene between man in a more civilised state, as we may hope, even than the Caucasian, and some ape as low as a baboon, instead of as now between the negro or the Australian and the gorilla' (Darwin 1874 in *The Descent of Man* p.178).

Freud, and later Jung, addressed American therapists in the 1920s with the following; 'the American black has what he calls probably a whole historical layer less' (cited by Thomas and Sillen 1972). Zahid (2017), argues that during the Second World War, doctors and psychoanalyst refugees who were mainly of Jewish origin were exposed to harsh racism when the British Medical Association opposed their entry to Britain, when fleeing Germany (Littlewood and Lipsedge 1989). In time, psychoanalysis

became a private paying contract between the therapist and the patient, which allowed race and social context to be ignored in favour of intrapsychic factors. Zahid suggests this experience of the Jewish psychoanalysts became a kind of 'ethnic cleansing' where they inversely repeated their past experiences so they became the oppressors by developing a therapy which ignored race.

2.6.1.2 Black Client White Counsellor Dyad

In her paper, Zahid (2017) raises the question: 'How do we address racism and cultural bias in the therapy world so that it isn't re-enacted within the therapeutic relationship?' Littlewood and Kareem (1998) point out the history of psychotherapy should not be underestimated. For example, how might a black or person of colour feel when confronted with a European/white therapist and European style of therapy? What emotions does it generate for the client to know that they are faced with their historical oppressors, and with whom they may associate a past of colonialism, slavery, and oppression? How is it to be in a relationship which is therapeutic by nature, but stands as a contradiction historically?

Zahid emphasised that cultural awareness training is key and that it is important to explore one's own prejudices, assumptions, and issues regarding race and racism (Thomas 1998) so that our cultural story does not unconsciously spill into the therapy room and prompt clients to disengage from counselling services. She warns, if therapists ignore race or don't deal with it adequately, there is a danger of the therapist and client re-enacting historical racist dynamics, and for the therapist to misjudge 'political' resistance as 'therapeutic' resistance.

2.6.1.3 Transcultural Therapy

According to Zahid Transcultural therapy challenges the dormant racism within psychotherapy. D'Ardenne and Mahtani (1999) believe transcultural counselling comprises the following:

- Counsellor sensitivity to cultural variations and the culture bias of their own approach;
- Counsellor's grasp of cultural knowledge of the client;
- Counsellor's ability and commitment to develop an approach to counselling that reflects the cultural needs of the client.

There are some black people who will only consider engaging with counselling if the therapist is black, often to minimise the risk of racism, misunderstanding or being pathologised. Zahid goes further, defining Transcultural therapy not so much as a type of therapy but more a philosophy as:

- Becoming aware of our own culture, assumptions, prejudices, and stereotypes;
- Working through the pre-transference;
- Learning about diverse cultures and their histories;
- Understanding the historical implications of race and racism within counselling and psychotherapy;
- Learning about slavery, colonialism, and oppression;
- Exploring the impact of oppression and race on the unconscious process;
- Exploring the dynamics of culture, race, and ethnic difference in the therapeutic relationship;
- Reviewing our own practice and considering what is multi-culturally therapeutic.

She concludes the impact of oppression and racism is far reaching for all cultures, past and present; and, it is essential for everyone to have a safe place to explore and heal from the trauma that has been carried by generations.

The emergence of Black Psychology which relates particularly to black understanding of self, society, and the world, providing an alternative to Euro-centric psychology was initiated by the Association of Black Psychologists, established in the United States in 1968.

2.6.2 Therapy and Religion

Religion and psychology have for centuries occupied polar positions, often regarding the other with suspicion. Interestingly, *psyche*, the root word of psychology, psychotherapy and psychodynamic translates to *mind, emotions and feeling*. But according to Jacobs (1998: 4), *soul and spirit* are more accurate descriptions. As the field has evolved there has been a deliberate attempt to move away from 'healing the soul/spirit', and essentially take out the spirit out of psychology. However, this is counteracted by Transpersonal and Existential therapies, Christian counselling and the BACP's Threshold journal, to name a few.

Leading figures within the field of therapy have been less than complimentary of religion for many decades. Freud's work was very much influenced by literature such as produced by Charles Darwin, above. Lukoff (2000), explores the perspectives of Freud and others and finds Freud promoted his view in several works, such as in *Future of an Illusion* (1927) wherein he pathologises religion as 'a system of wishful illusions

together with a disavowal of reality, such as we find nowhere else ... but in a state of blissful hallucinatory confusion'. Freud also promoted this view in *Civilization and its Discontents* (1930), where he reduced the 'oceanic experience' of mystics to 'infantile helplessness' and a 'regression to primary narcissism.' In Freud's short paper 'Obsessive Acts and Religious Practices' (1907), regarded as the first major essay in the psychology of religion, he suggests 'obsessional neurosis' may be taken as a pathological counterpart to religion as a kind of individual religiosity, with religion functioning as a universal obsessional neurosis. This theme was later developed in *Totem and Taboo* (1913) where Freud argues religion is based on the sense of guilt and the remorse of attaching to it. The 1976 report *Mysticism: Spiritual Quest or Psychic Disturbance* by the Group for the Advancement of Psychiatry (GAP) (1976) followed Freud's lead in defining religion as a regression, an escape, a projection upon the world of a primitive, infantile state.

Albert Ellis, the founder of Rational Emotive Therapy, is considered the forerunner of cognitive modification approaches now widely used in cognitive-behavioural therapies. In an interview in 2001, he said: 'Spirit and soul is horsexxxx of the worst sort. Obviously, there are no fairies, no Santa Clauses, no spirits. What there is, is human goals and purposes...But a lot of transcendentalists are utter xxxxxballs.' With regard to religion he said, 'The elegant therapeutic solution to emotional problems is quite unreligious. The less religious they [patients] are, the more emotionally healthy they will tend to be.'

B.F. Skinner, the psychologist who pioneered understanding of behaviour modification principles that are the other half of cognitive-behavioural therapies, did not publish a single word on the topic of spirituality observes Lukoff (2000). He

approached humans as stimulus response boxes with varying behaviours that depend on environmental factors. Skinner's psychology gave no attention to inner experience. According to Carroll (2013), Jung and a handful of other doctors stand apart from their colleagues, most other influential psychiatrists of the twentieth century chose to follow Freud or ignore the topic of spirituality in their writings. Despite this, research demonstrates that in their practices, psychiatrists are repeatedly faced with psycho-spiritual issues.

The views of the early founders on religion and spirituality have had a profound influence on clinical practice. Scott Peck (1990), author of *The Road Less Travelled*, highlighted the disastrous clinical consequences for all the mental health professions. Traditional neglect of the issue of spirituality has led to five broad areas of failure: devastating misdiagnosis; frequent mistreatment; an increasingly poor reputation; inadequate research and theory; and a limitation of psychiatrists' own personal development. As a result, research on both psychopathology and mental health has largely ignored religion.

Studies have also been carried out to explore religion in the consulting room. Increasing attention has been paid to how therapists might respond respectfully and usefully to clients' religious and spiritual beliefs and commitments (Coyle and Lochner 2011). Therapists are encouraged to engage constructively with clients' religious and spiritual material to enrich therapeutic experience and effectiveness. The writers mention that within Western liberal social discourse, religion has often been associated with negative qualities such as conflict, control, judgementalism and anti-intellectualism. To ignore or attempt to deconstruct the religious and spiritual aspects of clients could carry major adverse implications. As Bergin and Payne

(1991: 201) point out: 'ignorance of spiritual constructs and experience predispose a therapist to misjudge, misinterpret, misunderstand, mismanage, or neglect important segments of a client's life which may impact significantly on adjustment or growth.'

There is evidence that clients with strong religious beliefs may be wary of seeking therapy in non-religious settings because of such fears (Mayers et.al. 2007).

Crossley and Salter (2005) carried out a study of clinical psychologists' experience of addressing spiritual beliefs in therapy. They found that, while some practitioners reported a proactive approach, others waited for clients to raise spiritual issues on the assumption that if these were significant, the client would mention them without prompting, but this assumption may not always be justified.

How best practitioners can support the religious client has been the focus of some scholars. What seems to be required is the implementation of standard principles of good clinical practice and establishing a good therapeutic relationship. For example, some writers have considered how best to create a therapeutic space in which practitioners and clients can feel comfortable in raising and exploring religious and spiritual issues (Clarkson 2002; King-Spooner 2001; Purton 1998).

In the interest of spirituality and mental health, The British Association for Counselling and Psychotherapy (BACP 2011) produced a policy statement:

- BACP values the important role and contribution of faith communities in contributing to the health of individuals;
- BACP considers it important to respect the convictions of clients who have an allegiance to a faith community;
- BACP encourages high standards of training and awareness in spirituality and especially in its relationships to counselling and psychotherapy;

- BACP encourages counsellors and psychotherapists to engage with aspects of faith and culture if their clients bring these to counselling/psychotherapy.

A question posed in the BACP paper is: Can therapists work with clients whose belief system they do not share? Under the heading of Justice, The Ethical Framework (2010), states:

'A commitment to fairness requires the ability to appreciate difference between people and to be committed to equality of opportunity and avoiding discrimination against people or groups contrary to their legitimate personal or social characteristics. Practitioners have a duty to strive to ensure that a fair provision of counselling and psychotherapy services, accessible and appropriate to the needs of potential clients. Practitioners should not allow their professional relationships with clients to be prejudiced by any personal views they may hold about lifestyle ... belief or culture.'

Client feedback suggests that some therapists take a suspicious, even hostile attitude to the subject of religion. Clients may be anxious that faith issues will be considered pathological if brought to therapy, echoed by Dein (2004), who suggests many psychiatrists see religion as primitive, guilt-inducing, a form of dependence, irrational and having no empirical basis.

In order to promote effective therapy, the BACP suggest: spirituality, faith and religion might be included in both therapy and supervision training so that therapist and supervisors feel as competent to address these issues as they would any other, and

spiritual care could be raised to a higher profile in diversity discussion. It is unfortunate that the BACP do not see it as necessary to add more weight to its recommendations concerning religious expression and exploration, 'encourage' and 'might', implies this is neither a requirement or universal practice.

2.6.2.1 Christian Counselling

The Association for Christian Counselling UK (ACC) defines its work as activities that 'seek to help people towards constructive change and growth in any or every aspect of their lives, through a caring relationship and within agreed relational boundaries, carried out by a counsellor who has a Christian worldview, values and assumptions ... counsellors use different methodologies or models for their counselling depending on their training and what they find to be effective. However, they do not make any assumptions or have any requirements about client's beliefs and values, and they will not press their faith onto clients.'

Black Christians who are open to receiving therapy will sometimes request a Christian counsellor. This term can be defined in two ways: firstly, as an individual who is delivering a form of counselling which incorporates Biblical passages and viewpoints alongside other mainstream therapeutic approaches or secondly, mainstream counselling delivered by a Christian. The second is likely to use mainstream theoretical approaches, but is also able to facilitate the space to explore spiritual and religious issues with ease. There are ongoing debates about whether Christian counselling is equitable to mainstream counselling in terms of professionalism, training, quality and ethics.

Cognitive Behavioural Therapy (CBT) aims to help people manage their problems by examining (and ultimately changing) how they think and behave. The therapy combines a cognitive approach and a behavioural approach to make the link between thoughts and actions. CBT was revealed to be the most common form of therapy in the IAPT programme. In 2013–2014 alone, CBT accounted for 38 per cent of the total appointments, approximately three billion appointments (Counselling Directory 2016).

Dein et.al. (2010), identified some work examining the incorporation of religious activities such as prayer, Bible reading and ritual into CBT. Some evidence suggests that Christian-based CBT is more effective among Christian patients with depression and anxiety than traditional nonreligious CBT. Future work in this area should concentrate on which therapies are efficacious for which patients and which therapists should be conducting them (Propst et.al.1992).

2.6.3 Therapy Training

Despite an increased interest in multicultural counselling in the last two decades, adequate transcultural counselling training and practice is lacking, suggesting a gap in counsellor training, according to McKenzie-Mavinga (2005). Her research questions ask: 'How do trainee counsellors in Britain understand concerns about black issues, raised by themselves during their training or about clients during the therapeutic process? And is training that fails to address the dynamics of racism, and experiences that relate to black people inadequate?' The Race Relations Act 1976 now gives public authorities including Higher Education, a 'statutory general duty to promote race equality' (CRE. 2002). McKenzie-Mavinga writes the Act suggests that 'we' as a community of practitioners are responsible for change in the educational

process. Her thesis is based on evidence that counsellors training in a variety of settings had not received sufficient input to support the experiences of black people either in training or counselling settings.

Eleftheriadou (2015) argues that awareness of race, culture and diversity is a fundamental element of good professional practice and an imperative segment of training. Her paper provides a rationale for widening the scope of Counselling Psychology training to explicitly include and embrace the values of race, culture and diversity as well as acknowledging their impact. Since its conception in 2014, the Black and Asian Counselling Psychologists' Group (BACPG), is actively involved in raising awareness with positive results. They observe that issues around race, culture and diversity have been limited to a single-day workshop at a specific point in the training. Further, these workshops are often presented as non-compulsory. BACPG advocate for an on-going, continuous exploration of these issues, which ought to be implemented at each stage of the training programme.

One aspect of delivery highlighted by recent feedback from trainees suggested that the professionals delivering these courses ought to be representative of the communities, ethnicities, and diversities they are trying to raise awareness about. Psychology students (and other professionals) from ethnically diverse backgrounds have commented that training does not complement their experiences or speak to their identities as individuals (Ellis and Cooper 2013).

Eleftheriadou believes it is important, that Counselling Psychology training (amongst other factors) reflects the experiences of all individuals, particularly those from black minority ethnic backgrounds, and the reality of the multi-cultural and multi-social

society in which we exist. A lack of this incorporation can have wide and far-reaching consequences, including but not limited to: 1. Counselling Psychologists from BME backgrounds being alienated. This will continue to foster the perception that our professional body is not fully representative of the communities we serve; 2. The risk of fragmenting and/or re-traumatising clients because of a lack of knowledge, awareness and clinical experience; 3. Clients disengaging or terminating therapy due to therapist's lack of courage or knowledge to explore underlying issues pertinent to the process; 4. Ill-equipped professionals who are unable to deal with the dynamics of difference; 5. Personal and professional ignorance of practitioners' own identity construction, and position of privilege; 6. A dearth of information that would have otherwise informed the Counselling Psychology practice (ibid).

Alongside practitioners' effective response to the religious client is the need for adequate clinical supervision. Aten and Hernandez (2004), argue religious engagement needs to be accompanied by training for supervisors so that practitioners can feel comfortable and confident in exploring religious and spiritual issues within supervision.

With the increase of people experiencing mental health concerns, the financial strain on services is rising (Counselling Directory 2016). Figures show mental health problems constitute the largest single source of world economic burden. Its estimated global cost is £1.6 trillion greater than cancer, diabetes, chronic respiratory disease and heart disease on their own (Insel 2011). Mental health distress costs the economy in England £105 billion each year (Centre for Mental Health 2016). Mental health services in the UK are overstretched and investment in mental health prevention is limited. With regard to talking therapy there is a growing range of talk

therapies now available, however, according to the 2014 survey carried out by the We Need to Talk Coalition, out of 2,000 people who tried to access talking therapies only 15 per cent were offered the full range recommended by the National Institute for Health and Care Excellence (NICE), 13 per cent had a choice of where they received therapy and half had a choice about the time of their appointment.

2.6.4 Mental Health Professionals and Delivery of Services

The Royal College of Psychiatrists Special Interest Group on Spirituality (PSIGS), continues to highlight the need for all mental health professionals to be sensitive to spirituality, culture and religion. Psychiatrists need to understand how religion and spirituality affect their patients' lives in illness as well as health, and how spiritual and religious values can be harnessed to facilitate the healing process (Cook et.al. 2009) The growing interest in this area from within the profession as well as service users, supports the view that an understanding of the relationship of spirituality and religion to mental health, far from being an optional extra, should be counted as essential to good clinical practice (ibid).

Echoing this view, Dein et.al. (2010) assert research demonstrates important associations between religiosity and well-being; spirituality and religious faith are important coping mechanisms for managing stressful life events. Despite this, there is a religiosity gap between mental health clinicians and their patients. The former are less likely to be religious, and recent correspondence in the Psychiatric Bulletin suggests that some at least do not consider it appropriate to encourage discussion of any spiritual or religious concerns with patients. However, it is difficult to see how failure to discuss such matters can be consistent with the objective of gaining a full

understanding of the patient's condition and their self-understanding, or attracting their full and active engagement with services.

Dura-Vila et.al. (2011) stress the need for compassion, empathy and 'spiritual competencies' within health services including psychiatry. While the United Kingdom is supposedly a secular society, a high percentage of NHS clinicians come from religiously oriented backgrounds; and little is known about how the religious beliefs of such professionals are resolved in a secular practice. This qualitative study explores psychiatrists' attitudes to religion and spirituality within their practice and examines how these are resolved in the therapeutic relationship with, and management of, religious patients. Twenty interviews were conducted with psychiatrists working in London. The main finding was the strong degree of dissonance amongst the migrant psychiatrists between their practice in their home countries (incorporating patients' religious beliefs) and in the United Kingdom (excluding them). Dura-Vila et.al. (2011) recommended a need for further training in this area.

2.6.5 Perceptions of Health, Illness and Healing

Healing, according to the Oxford Dictionary is defined as the process of returning to health; the restoration of structure and function of injured or diseased tissue; the process of helping someone return to health.

Allan Anderson (2000), has made a substantial contribution to critical thought on Pentecostalism in the UK today. He asserts that healing is central to many world religions, including Pentecostal Christianity. He focuses on African Pentecostalism, highlighting that for some, faith in God's power to heal directly through prayer

resulted in rejection of other forms of healing. Other writers feel traditional healing practices have a place in caring for individuals who are unwell. There is the suggestion that the process of healing should involve modern medicine working together with traditionally or culturally informed practices (Thachil and Bhugra 2009). For example, successful outcomes have been reached in cases where a combined approach was used (Jilek and Draguns 2008; Moodley et.al. 2008; Thachil and Bhugra 2009; Wintrob, 2009). Given this, though complex, the integration of evidence-based reasoning, and traditional beliefs in the spiritual and in 'balance' may produce the best outcomes (ibid).

Lago and Thompson (1998: 84), in *Race, Culture and Counselling* explain the ways in which people cope, attempt to solve their problems and seek assistance are shaped by the social and cultural norms and symbolic meaning within their culture. Some authors have pointed out that differences do exist between cultures on what is even deemed as problematic (ibid).

Tseng and Hsu (1979), developed a useful model of contextualising healing activities. They assert that in all cultures at all times there have been four dominant modes of healing: supernatural intervention; social interaction; principles of nature and bodily functioning. Historically, doctors, priests and traditional healers were considered the main helpers and healers in society, but with the growth of different forms of therapy, now each of these activities are carried out by different practitioners rather than one helper treating the 'whole person'. Essentially, the western development of expertise has led to a separation of the four domains to form a different type of matrix, which encompasses medicine, priesthood, behaviourism and therapy (ibid).

Green et.al. (2002), writes that medicine is considered both the art and science of healing. Developed during the age of Enlightenment in the 18th Century, the belief that science could cure all illness and disease has remained a core element of modern medicine (Community Development and Health Network 2009). However, there is growing concern that with the changing cultural diversity of our population physicians are required to develop new skills in communication and negotiation with their patients. Nevertheless, managed care constraints, litigation, and growing regulatory pressures have compromised communication and trust between physicians and patients. This, along with the surge in technologic development, has driven the medical system even further towards a 'disease-based' approach to health care that views individuals as 'cases' and undervalues the sociocultural and humanistic aspects of patient care. The authors make a distinction between disease and illness: disease is defined as a pathophysiologic process, illness is defined by the complete person – physical, psychological, social, and cultural (Eisenberg 1977; Helman 1981) and the healing tools and instruments of science are blunt and ineffective when used blindly in ignorance of the meaning and context of a patient's illness.

The social action model of health examines all the factors which contribute to health such as social, cultural, political and the environment. It is well documented that stress, low self-esteem and lack of autonomy can have a negative impact on health (Community Development and Health Network 2009).

Within BMCs pastors and leaders play an important role in influencing members choices and attitudes towards healing.

2.6.5.1 Pastors and Leadership Teams

The pastor/church leaders are considered by many as 'gatekeepers'; they can influence the route church members may take in managing their distress. Help-seeking families have a similar perception and expectation of the professional as they do of their pastor, to whom they look for a cure. Powell (2016) found that at times, the issue of mental health was thought to be beyond the expertise of the church and that non-religious professional help was appropriate. The perceived expectation of the help seeker is sometimes met by ambivalence where the pastor fluctuates between offering prayer and religious counselling and referring the person to professional services. Powell highlights the tension between the sacred and secular; the religious discourse that provides the relational frame for the pastor and the congregational member, privileges the sacred over the secular; prayer is always the first recourse before external agencies are involved.

2.6.5.2 Leaders' Influence on Interpretation of Problems

Powell's (2016), significant unpublished study entitled 'How Black Pentecostal Pastors Conceptualise Mental Health' centres around three participants who are pastors within black Pentecostal churches working in urban areas of South London. Three themes emerged from the data: pastor's relationship to mental health; spiritual beliefs about mental health; perceptions of outside help. Findings revealed that regarding their relationship to mental health, there was a direct correlation between the pastors' perception of mental health and the help and support individuals and families received. Self-disclosure is seen as a way of challenging stigma and fear, and in doing so pastors achieved a level of congruence with help seekers that allowed them to share openly without fear of being shamed or stigmatised.

With regard to spiritual beliefs about mental illness, a lack of training meant that responses were drawn primarily from held spiritual and cultural beliefs about mental health. Belief in the presence of the supernatural in mental illness ranged from firmly held belief to syncretism and varying levels of ambivalence. Attribution of blame/cause included generational curses, moral failure or inexplicable malevolent forces. However, pastors who had access to psycho-education were more likely to recognise and acknowledge bio-psychosocial causes. The notion of 'original sin' meant that any intervention to address the human condition in the first instance was spiritual. The pastors agree that attributing biological, emotional, social or religious causes to an illness, affects the way the mentally distressed person is positioned within the church community. Pastors who believe in a supernatural causation were less tolerant in their views towards those who are experiencing mental illness (ibid).

The practice of Deliverance (akin to exorcism) is exercised by most Pentecostal pastors and more so among West African leaders. Participants described deliverance as a more intense form of prayer where the perceived role of the pastor is to act upon the help seeker and supernaturally free them from an evil spirit.

Psychiatrists Bhui and Bhugra (2003) take issue with and write in response to Dein's (2002) comments on their editorial on 'Explanatory models in psychiatry'. They make a number of observations which include the issue of exorcism. (Explanatory models represent the patient's personal conceptualisation of the cause, course, and consequences of their illness. Their experiences and belief systems are ingrained in their cultural and social world). Bhui and Bhugra argue Dein fails to apprehend the conceptual flaws in his assertions; he promotes a complacent attitude to the challenges of cultural psychiatry, and is threatened by a patient's explanatory model

that differs from his own. They ask: 'Why is an exorcism problematic for the psychiatrist?' It is not in the realms of psychiatric knowledge or skills, and if helpful for recovery from illness, rather than disease, it should not be hindered.

Powell found the perception of outside help was mixed, most pastors had direct contact with mental health practitioners. The pastors' view of professionals was both critical and complimentary. Secularised Western education's perception of religion as a primitive construct contributes to the polarity. Powell recognised the sacred and the secular seem to arrive at similar conclusions; that the help seeker has a presenting problem but they seek to address the issue from the basis of their respective epistemologies. In addition, the hierarchical structure within the church organisation resembles the mental health profession with its rank of consultant psychiatrist, clinicians and offshoot disciplines.

2.6.5.3 Black Leadership and Training

Muir (2015) suggests the picture is changing compared to previous decades and Pentecostals and Charismatics are receiving theological education and ministerial training in a variety of educational environments, including confessional and ecumenical ones. He observes new enthusiasm among Pentecostals and Charismatics for leaders to be better trained and 'equipped for the ministry'.

Although Howard (1987) lists various programmes open to pastors, there appears little evidence of mental health awareness modules incorporated in their design. Muir (2015) also provides a detailed list of the various theological courses available around the country in his discussion paper on 'Theological training among British

Pentecostals.’ A number of BMCs and Charismatic churches design and deliver their own training programmes, which are often not recognised outside of their church circles, raising quality assurance concerns. However, there are several BMCs offering accredited courses, for example New Testament Assemblies in Tooting includes Pastoral and Christian counselling programmes.

The concern is that not only should leaders receive adequate theological training, but also, that they receive support to be emotionally healthy leaders. In his book *The Emotionally Healthy Leaders*, Scazzero (2015: 27–32) identifies four characteristics of the emotionally unhealthy leader: low self-awareness; prioritises ministry over marriage and singleness; does more ‘for God’ than their relationship with God can sustain; lacks a work/Sabbath rhythm.’ Healthy leadership encompasses many factors but in practising self-care, the congregation may adopt similar behaviour. Ultimately, a healthy church should promote an inclusive and understanding environment for those experiencing mental health difficulties whether they are leaders or members.

2.6.6 Religious Coping

The American Psychologist Ken Pargament (2010), suggests there are two sorts of coping: positive religious coping and negative religious coping. Positive religious coping (for example benevolent religious appraisals, religious forgiveness) reflects a secure relationship with God and is associated with improved mental health. In contrast, negative religious coping (for example reappraisals of God’s powers, feeling abandoned or punished by God) reflects a tenuous relationship with God and is associated with a decline in mental well-being.

In 1999, an in-depth qualitative study was conducted by Cinnirella and Loewenthal involving 52 female participants from the following urban-dwelling religious groups: White Christian, Pakistani Muslim, Indian Hindu, Orthodox Jewish and African-Caribbean Christians. Qualitative thematic analysis of open-ended interview responses revealed that the degree to which religious coping strategies were perceived to be effective in the face of depressive and schizophrenic symptoms varied across the groups. Prayer was perceived as particularly effective among African-Caribbean Christian and Pakistani Muslim groups. Across all non-white groups, and also for the Jewish group, there was fear of being misunderstood by health professionals, and among African-Caribbean Christian and Pakistani Muslim participants, there was evidence of a community stigma associated with mental illness, leading to a preference for private coping strategies.

Religious factors were clearly seen as important in managing mental illness, and this has implications for help-seeking and adherence. In a later study 'Faith conquers all? Beliefs about the role of religious factors in coping with depression among different cultural-religious groups in the UK', Loewenthal et.al. (2001) conclude that among religious activities, faith and prayer were seen as most helpful.

It is also possible that the beliefs and teachings advocated by a religion – like forgiveness, love and compassion – may become integrated into the way the brain works, claims Newberg (2010), a neurotheologist. He asserts the more that certain neural connections in the brain are used, the stronger they become; thus, if a religion advocates compassion, the neural circuits involved in thinking about compassion become stronger. Each time these positive feelings and emotions are revisited, stress and anxiety are reduced. This, in turn, can also lead to a reduction in stress hormones. Some religions also advocate that members stay away from high-risk

health behaviours, such as smoking, drinking alcohol or overindulging in food. Steering away from these unhealthy behaviours could also be beneficial (ibid).

2.6.6.1 Faith

The Collins Dictionary definition of faith is ‘complete trust or confidence in someone or something; a strong belief in the doctrines of a religion, based on spiritual conviction rather than proof.’ Moll (2014) writes about ‘The Surprising Links Between Faith and Health’, and argues that faith gives people a sense of meaning and purpose in life, which is linked to better health. Even though religious people tend to be affected less by depression, Christians still suffer from depression and other forms of mental illness. But while faith is certainly no cure for any mental illness, which is contrary to Pentecostals’ beliefs, the author believes it does seem to offer an additional buffer against its worst effects. Faith and spirituality are abstract concepts, but they can lead to concrete results in mental health improvement and stress reduction (Hansen 2014). According to Moll, faith generates optimism, enriches interpersonal relationships, creates support systems and enhances quality of life. Scientific research also demonstrates connections between religiousness and improved mental health, as mentioned previously.

Faith is ‘good for your health’, according to Adams (2011) writing for *The Telegraph*. Believing in God is good for your health; being a practising Christian is good for your health, according to a report by a group of doctors, because it makes you happier and more optimistic. Based on evidence from over 1,200 studies and 400 reviews the overwhelming majority of scientific studies highlight the positive health benefits of faith, including protection from illness, coping with illness, and faster recovery from it.

2.6.6.2 Meditation

Meditative or contemplative practices have been around for centuries and are an integral part of Christianity and other world religions. Journaling is often an overlooked contemplative practice that can help a person become more aware of their inner life and feel more connected to their experience and the world around them. Studies show that writing during difficult times may help people find meaning in life's challenges and so an individual can become more resilient in the face of obstacles. According to Grothaus (2015), Pennebaker, a psychologist and leading expert in the field of Expressive Writing has shown journaling strengthens immune cells called T-lymphocytes and has been shown to be associated with drops in depression, anxiety, and increases in positive mood, social engagement, and quality of close relationships.

The non-religious alternative to meditation is Mindfulness. Davidson (2012) is best known for his ground-breaking work studying emotion and the brain. His research has shown that meditation increases the brain's grey matter density, which can reduce sensitivity to pain, enhance the immune system, help regulate difficult emotions, and relieve stress. Mindfulness has become increasingly popular in recent decades, an integrative mind-body therapy, mindfulness looks to help people manage their thoughts and change the way they relate to experiences. It works by encouraging individuals to focus on the present moment and draws on meditation techniques. In particular it has been proven helpful for people with depression and anxiety, cancer, fibromyalgia, chronic pain, rheumatoid arthritis, type 2 diabetes, chronic fatigue syndrome, and cardiovascular disease. Mindfulness is recommended by NICE as a preventative practice for those with recurrent depression. According to the Mental Health Foundation (2014), studies show that mindfulness-based stress reduction leads to a 70 per cent reduction in anxiety.

2.6.6.3 Prayer

Meditation is an important calming and coping strategy for many Christians. Prayer is considered an example of this. Prayer in the context of Christianity is a form of communication to or with God and can take several forms, such as spoken prayers, silent prayers, written prayers, prayers that are sung, prayer walks and prayers of the mind and heart. Prayers may be directed for example, prayers for specific things or non-directed, with no specific outcome in mind.

Research demonstrates that prayer may elicit the relaxation response, along with feelings of hope, gratitude, and compassion – all of which have a positive effect on overall well-being. There are several types of prayer, many of which are rooted in the belief that there is a higher power that has some level of influence over your life. This belief can provide a sense of comfort and support in difficult times; a recent study found that clinically depressed adults who believed their prayers were heard by a concerned presence responded much better to treatment than those who did not believe (Duncan 2016).

In her paper 'Prayer and Medicine, a Healthy Alliance? A Multi-faith, Multi-cultural Perspective' Raji (2004) reviews studies demonstrating the benefits of prayer (McCullough 1995; Levin 1996; Dossey 1996; Paloma 1993). She argues that prayer forms part of holistic care in the clinical setting. However, the questions that arise are how, when, why and with whom to pray? Winslow and Winslow (2003) recommend careful reflection about the meaning and purpose of prayer in the clinical setting before engaging in prayer with patients.

Raji states that people pray for different reasons, which include: moving closer to God and staying connected (for someone who already believes); awareness of God because of threat to one's existence through illness; questioning one's existence, searching for the meaning of life; hoping to get better; preparing for the 'hereafter'; to find relief in suffering; and as a confidant or counsellor. Sometimes this replaces the need for a physical person to share concerns with. When it has been established that a patient would like to be prayed with, Raji says, it becomes important to establish the form of prayer most suited to a patient's needs. Prayer can be petitionary, meditative, intercessory, liturgical, transactionary, conversational, private or an act of supplication. In addition, psychological and physiological conditions have an impact on praying (Hawley and Irurita 1998). On one hand, illness can increase the frequency and intensity of prayer, on the other hand, it can also produce a challenge to one's customary prayer experience (Taylor 2003). The challenge could be due to one's physical state, psychological adjustment to the illness and conflicts about prayer, or the physical environment of being in hospital. It then becomes necessary to recognise and address these issues with the patient before prayer can become helpful for coping.

According to Jonas and Crawford (2003), surveys indicate that nearly 90 per cent of patients with serious illness will engage in prayer for the alleviation of their suffering or disease. Among all forms of complementary medicine, prayer is the single most widely-practiced healing modality. Prayer is said to improve health by imitating the relaxation response which induces anti-oxidation and anti-inflammatory changes that counteract the effects of stress on the body, which in turn lowers blood pressure and other factors heightened by stress; helping the individual release control to something greater than oneself, which can reduce the stress of needing to be in charge; prayer can enhance a person's hopes and expectations, and that in turn can

positively impact health; it can bring a sense of a spiritual or loving presence and alignment with God; can elicit feelings of gratitude, compassion, forgiveness, and hope, all of which are associated with healing and wellness; mind-body-spirit connection - when prayer uplifts or calms, it inhibits the release of cortisol and other hormones, thus reducing the negative impact of stress on the immune system and promotes healing (Duncan 2016).

The issue of praying with patients is a contentious one, say Dein et.al. (2010) in their response to Koenig's paper in which he advocates for prayer to be available to patients, Dein et.al. argue that for certain patients, this might be helpful and could potentially strengthen the therapeutic alliance, but advocate extreme caution (as does Koenig 2008) in responding to a patient's request to join with them in prayer.

The issue of prayer (and the use of religious/ spiritual healing generally) raises significant issues about boundaries, the role of the psychiatrist and the ethics of self-disclosure. Where should the line be drawn? If a psychiatrist prays with their patients, could it be argued that they should be willing to read the Bible or other sacred texts with the patients, in order to quote passages that are felt to be healing? Again, this proposition will raise significant ethical dilemmas. The general consensus is referral to clergy is the best response in such circumstances. Some high-profile cases in the media where workers have prayed with patients have usually ended in dismissal.

Scott (2014), a medical doctor, in his book *Christians in the Firing Line* writes about his experience of disciplinary action for talking about the Christian faith with a patient, having been given permission by the patient to do so. The book examines the cases of thirteen people who have been warned, blacklisted, suspended or dismissed for acting in line with their Christian faith in the UK.

Despite a clear correlation between prayer and well-being, scholars have identified a number of issues with research on prayer such as: small sample size; participant selection; control group uncertainty; no common, agreed-upon methodology; quantification of prayer; how can we tell whether a higher power is intervening? how do we measure God?

2.6.6.4 Worship

Krause and Hayward (2013) conducted an interesting study titled 'Emotional expressiveness during worship services and life satisfaction: assessing the influence of race and religious affiliation'. The purpose of this study was to see whether an emotional expressive worship style can be associated with life satisfaction. The study model contains the following core relationships: (1) black people are more likely than white people to worship in conservative Protestant congregations; (2) members of conservative congregations and black people will attend church services more often; (3) black members and conservative Protestants are more likely than either whites or members of other congregations to openly express their emotions during worship services; (4) individuals who express their emotions during church services will be more likely to say they worship in a highly cohesive congregation; (5) people who worship in highly cohesive congregations will generalise this sense of connectedness to people outside their place of worship; and (6) those who feel closely connected with all people will experience a greater sense of life satisfaction. Their findings from a nationwide survey, provide support for each of these relationships.

Pentecostal worship is often very expressive and involves the releasing of a range of emotions. Some black Christians would describe this as a therapeutic experience in

that they are letting go of built up emotions, and freeing themselves of negative thoughts.

2.6.6.5 Singing and Dancing

Pentecostal worship incorporates copious singing and dancing. The benefits of collective singing have been proven to be many and various. In particular, there are positive physical outcomes and mental health benefits. According to Welch (2015) these are related to improved cardiovascular fitness (including lung function), as well as improved mood and general alertness, often allied to a feeling of being spiritually uplifted. Because singing involves many different areas of the brain acting in concert, there are often associated with cognitive benefits. There are also social and psychosocial benefits, as singing in a collective can improve participants' sense of belonging and of being socially included by engendering a positive sense of community. Benefits are available across the lifespan and are indicated pre-birth in the final months of foetal life. At the other end of the lifespan, singing can bring a stronger and more positive sense of identity in a context where there is often a sense of loss of control due to the challenges of ageing.

Rath (2018) discusses the health benefits of dancing. Dancing, uses and strengthens your emotions, cognitive skills, physical abilities and social connections – all of which are vital skills for daily life. Dancing requires you to use lots of different parts of your body – from your head and neck right down to your toes. Research also suggests that dancing has a range of mental health and well-being benefits. A review of research looked at the evidence for the effects of dancing and Dance Movement Therapy (DMT) (2017) over the last 20 years, and included 23 studies. Overall the review findings suggested that dancing has a positive effect on quality of life, body

image and mood. It also found that dancing reduced depression, decreased anxiety and boosted the mood (ibid).

2.6.6.6 Faith Communities (Church)

Mental Health charities in the UK such as Mind and the Mental Health Foundation (2014) emphasise the importance of being connected to others to maintain good mental health. Social support has been shown to reduce the psychological and physiological consequences of stress, and may enhance immune function. Social networks, whether formal, such as a church, or informal meetings with friends provide a sense of belonging, security, and community. People who are supported by close relationships with friends, family, or fellow members of church, work, or other support groups are less vulnerable to ill-health and premature death. Studies have shown a strong link between social support and measures of well-being.

2.6.6.7 Church Attendance and Membership

The report, *Health Benefits of Christian Faith*, was compiled by two doctors, Bunn and Randall (2011). They highlight one study which showed regular churchgoers had life expectancies up to 14 years longer than those who did not attend services. Health benefits associated with church membership include an increased sense of well-being, hope and optimism; lower rates of depression and suicide; less loneliness and less alcohol and drug abuse. The authors say their conclusions are backed by Andrew Sims, a former president of the Royal College of Psychiatrists, who lamented the lack of attention that was given to the health benefits of faith/faith communities.

2.7 Partnership Working

There are times when the help required to assist people in distress is beyond the expertise provided in the church. Sometime individuals seeking help prefer to have other options and are more comfortable working with professionals not connected to their place of worship. A number of authors have already endorsed the notion of BMCs and statutory services working more closely together (Time to Change 2014). There are examples of this union already happening. However, in order to provide a more holistic and cohesive approach, both sides will inevitably need to collaborate more widely to forge stronger relationships.

Summarising, Powell (2016) asserts the shift in UK government policy for mental health care towards a social model has given rise to new pathways of partnerships (Department of Health, 2011a). There are prevailing concerns that public agencies are not doing more to engage significant institutions and actors within the black community at critical levels of the process. The wider acknowledgement of social capital and hidden resources within BME communities does not go far enough to recognise the utility of the Black church and the role black Pentecostal pastors could play in early intervention as well as providing ongoing support for families coping with mental illness.

Powell recommends the gap in the pastor's knowledge about mental health is an opportunity for the church to incorporate mental health and psychotherapy training into its programme. There is a need for pastors and professionals to invest in new relational building and engage in more meaningful and respectful dialogue.

Thoughts and Reflections

The general picture of mental health care for black people in the UK appears somewhat bleak. McKenzie (2007) highlights not only are Africans and Caribbeans over-represented in psychiatric units by three to fourfold, but another group is beginning to stand out, those who define themselves as 'black other'. He explains the vast majority of this group are young, British-born black people, who are eighteen times more likely to be in hospital than the British average.

Although he suggests statistics should be treated with caution, years of research and an international review all conclude that migrants are more likely to develop mental illness; but the risk is doubled in black migrants and the risk increases again in their children. The issue is more than simply migration, it is about being a black person living in a white-majority country. McKenzie points out the rate of serious mental illness in the Caribbean and Africa is not high, but the rate of mental illness in Britons of Caribbean and African origin is.

With some of the best mental health services in the world, McKenzie asserts the UK are nowhere near a cure for psychosis. Where there is no cure, prevention is crucial and where there is an increased rate of illness in a group, they should be the target for prevention. But the UK has no prevention strategy. Psychotic illnesses are associated with poverty, poor education, living in a city, poor obstetric care, head injuries or brain infection in infancy or childhood, childhood trauma, family break-up and cannabis use. Targeting childhood and adolescence is therefore very important. McKenzie warns the high rates of mental illness in people of Caribbean and Africa origin are not diminishing; if anything, their legacy will blight a generation and the impact will be felt by generations.

The project has introduced the reader to the history of early African religion, the birth and growth of Pentecostalism in the UK, and explored how faith and a faith community impact health and well-being. The impact of slavery on the collective mental health of the African/Caribbean diaspora is impossible to fathom or quantify and cannot be overlooked or dismissed. With advances in science, research conducted by Hackett (2013) into epigenetic inheritance demonstrates how genes could retain memory of their past experiences, and potentially explain how (fore) parents' experiences could be passed to their offspring's genes and subsequently, future generations. This has huge implications for the black client.

Writers like Lindsey (2016), a professor and mental health researcher, suggest black mental health is not the same as white mental health. Epigenetic inheritance studies have shown how Holocaust survivors pass down scarred genes to their descendants – scars caused by extremely stressful conditions. Thus, the collective experiences of a people become individualised, passed down person by person from one generation to another. Lindsey further points out that many black individuals suffer in silence when experiencing mental illness due to stigma in their communities, this undoubtedly includes church communities too. Lindsey believes the scars of slavery are not only passed down through culture, but also through genetic manifestations. This perspective has implications for service-providers to have the necessary level of appropriateness and sensitivity when delivering therapeutic and mental health interventions to black people.

The BMC has shown resilience, strength and commitment. Churches have contributed greatly to the health and well-being of its congregations for decades. But

in changing world with ever increasing stressors and challenges how does the church impact mental health? The literature reveals black people/Christians tend to avoid statutory services for fear of being pathologised, or of medicalisation, and avoid sharing problems within church settings for fear of stigma or over-spiritualising/demonising the problem. The black Christian can be further ostracised when approaching therapeutic services and faced with 'unbelieving' practitioners who may view religion in a negative light. The black Christian is therefore let down when they need help the most.

The next section details the research process and will examine interviews with black Christians, who share their experiences, ways of coping with distress and perceptions of help both secular or church based. They also suggest resources or interventions which might be more useful to them in the future.

3. Research Methods

In the early stages of the Doctoral programme, while attending the Research Challenges module, research students were encouraged to explore and identify an appropriate methodology and methods with which to assist in data collection and data analysis; the final outcome being a robust, high-quality research project, presented in a clear and coherent fashion.

A qualitative research study was the chosen research for this study, primarily due to the emphasis on verbal accounts; concerned with words rather than numbers normally associated with quantitative studies. Qualitative research involves observing, describing, interpreting, and analysing the way that people experience, act on, or think about themselves and the world around them (Bazeley and Jackson 2013). According to Bryman (2008) qualitative research has five main preoccupations: seeing through the eyes of research participants; description of context; process; flexibility and lack of structure; and concepts and theory as outcomes of the research process.

In order to fulfil these five areas, a number of methodological approaches were considered before reaching the final decision to utilise a thematic tool. The process is explained in further detail below.

3.1 Focus Groups: The Research Questions

After several attempts the project title was formulated, followed a period of crafting the associated research questions. I tested the questions asking feedback from critical friends, fellow researchers and my Academic supervisor. A period of time followed to consider the method(s); ultimately, I wanted a tool that would generate rich and engaging data, bringing the study alive whilst addressing the research questions.

A number of factors contributed to the framing of the research questions; they were developed out of personal and professional experiences already mentioned in the Introduction, (Section 1). I wanted to get a sense of: black Christians' responses to maintaining their own mental health; what black Christians felt the responsibility of the church was in addressing mental health issues; what the current practice and provision was within their churches, how they perceived and experienced external statutory mental health services including therapy, and what role all these factors played in times of distress. Another important feature that influenced question design was the diverse audience I wanted to engage: Pentecostal/Charismatic church leaders, faith-based organisations, statutory services, policy makers, government departments, the therapeutic field, mental health charities, health professionals, and anyone with an interest in the association between of spirituality and religious faith and mental health. The intention was to illicit information and stories illustrating how black Christians interpret emotional and psychological problems, the kinds of strategies and services or inventions that are helpful in managing distress, what factors influenced their decision in eliciting that help? And the role of faith and the church in maintaining mental health – how exactly did they impact?

3.1.1 Semi-structured Interview Questions

The questions were devised to allow participants space to provide detailed responses to the questions with a view to using the findings to inform practice, policy and church culture; influencing the type and quality of services/interventions offered, particularly to black Christians. The questions were also designed with past and current literature in mind. The lack of British studies in this area and repeated appeals for more research sensitive to cultural, racial and religious contexts meant the questions attempted to redress this imbalance. The research questions are simple and open-ended in style and were designed to expand the title and capitalise on participants' responses allowing for depth and breadth.

A number of factors were instrumental in the decision to employ a semi-structured interview: the use of original questions lent itself to this approach; this was conducive to the research area which required detailed accounts of subjective experiences. These questions would have been difficult to quantify had a more rigid structure been utilised. Hence, this was considered the most effective and efficient means of data collection, increasing the potential for the emergence of useful and interesting data.

Five semi-structured interview questions were designed with additional prompts and emerging questions to generate further discussion if needed. These questions were tested in a research group and among critical friends who provided comments and suggestions to improve the clarity of the questions.

Focus Groups Interview Research Questions

(See Appendix 8: Research Questions, Prompts and Follow-up Questions)

- 1. How do you support yourself through times of emotional distress?**
- 2. What factors affect your choice when seeking help?**
- 3. What support does your church provide to individuals experiencing mental health or emotional issues?**
- 4. Do you think faith and faith communities play any role in maintaining mental health and well-being?**
- 5. Can you identify any positive or negative effects religious faith and faith communities may have on mental health and well-being?**

Each question dealt with a particular aspect of the black Christian's experience or perception of help and support with regard to mental health and well-being, and how this impacted them. The questions are at the heart of the project and is the central thread running throughout all sections. The questions were straightforward, using simple language to enhance clarity.

The original intention prior to presenting my Learning Agreement to the Assessment Panel, was to facilitate up to twenty individual interviews. Consequently, I considered Grounded theory as my means of data analysis; it produces theory from the data and links cause and effect. It is designed to ensure interpretation of data is carried out in a comprehensive and systematic manner, developing explanatory models (McLeod 2011). In Grounded theory the focus is on achieving general findings that are attributed to a whole sample (McLeod 2011). However, it seemed a little rigid. I felt I needed more flexibility; furthermore, my participant numbers were too large, resulting in a 'misfit'. Case study and autoethnography were also explored but later rejected

on the basis they would not generate the type of data relevant to the audience of the study, and may limit the depth and range of participants' responses.

Eventually, Interpretative Phenomenological Analysis (IPA) was the selected mode of data analysis, because it seeks to capture and represent the lived experience of participants and was therefore better suited to the study. IPA employs a sequential set of interpretive 'readings' of the data as opposed to open coding used in Grounded theory (McLeod 2011). Semi-structured interviewing is compatible with several methods of data analysis including Interpretative phenomenology (Willig 2001). IPA allows for flexibility and does not require the researcher to construct a model but is sensitive in describing and exploring differences between participants. However, late into the doctoral journey it became apparent during a number of Professional Knowledge Seminars that IPA was not best suited for my research after all, because one of the criteria for its use is small participant numbers, normally no more than five or six. So, for some time I felt very stuck and anxious, my methodology was not appropriate for the type of study I was conducting. However, discussions with the Assessment Panel during my Learning Agreement Presentation provided a promising alternative.

The panel felt the project was significant enough to warrant a larger participant size; as an original piece of research I could exploit the opportunity further to generate more data to work with. I was encouraged to increase participant numbers dramatically from twenty to one hundred, to facilitate several focus groups, and select five to six individuals from the focus groups to take part in individual interviews to further expand themes, ideas and generate theory. Panel members suggested the use of Thematic Analysis (TA) to examine the data and from this point I felt clearer. I

set about reading material, past and present papers as well as research studies which utilised TA (Braun and Clarke 2006; Boyatzis 1998). Given the study was considered the first of its kind, it was felt high numbers would produce rich data and an informative study. Also, I later attended session at Metanoia's Research Academy of which one session was dedicated to TA facilitated by Dr Nikki Hayfield. This event crystallised my thoughts around TA and helped to prepare me for data analysis and the writing up stage.

Naturally, the prospect of my research quadrupling in size was a daunting one. I was pleased with the level of interest but at the time didn't fully appreciate how much work would be involved in organising and managing over a hundred participants. My delight that I had actually found the right 'fit' for the study superseded my anxieties about participant numbers at the time. This method complemented the project and would support data collection and analysis and assist in keeping the research questions at the forefront of the process. Inevitably, there were huge implications with regard to time management; in essence I re-adjusted my timetable to account for the huge amount of material that would be produced, allowing time for conducting, processing and meaning making of interviews.

The revised proposal took into account the size of project that was manageable for a lone researcher; I planned to conduct ten groups, with six to ten participants in each group. Focus group interviews are considered less time consuming and expensive and allow the facilitator to draw out the beliefs and attitudes of participants, thus producing a rich source of qualitative data (McLeod 2003). To capture a range of experience and perceptions, a broad spectrum of individuals would be invited to participate in the focus groups such as, church leaders, health professionals, senior

citizens, young people and service users. The purpose of focus groups is to generate additional data through interaction between participants, to develop themes which emerge from the individual interviews and to add rigour to one-to-one interviews (King and Horrock 2010). I felt the inclusion of black Christians from diverse backgrounds would undoubtedly add another dimension to the study and could throw up some interesting views and differences within and between groups.

Through this group process the intention was to provide detailed insight into the BMC and the experiences of its members. King and Horrock (2010) suggest that a situation where people are interacting as part of a group is more 'naturalistic' and closer to everyday life than an individual interview. Focus groups have been shown to capture participants' priorities, language, understanding and group norms (McLeod 2003). Furthermore, they are useful when exploring sensitive topics, such as the negative impact of the church on mental health. Knowing other people are participating, feeling less exposed, awareness of people with similar experiences or views, have all been cited as reasons for exploring sensitive issues in a group setting (ibid).

3.1.2. Individual Interview Questions

Regarding the construction of the Individual interviews, they emerged out of the focus group experience and were designed later on in the process. This is, of course, a completely subjective exercise, and anyone attempting to repeat this study would no doubt put forward a very different set of questions; such is the dynamic nature of qualitative work; it evolves and the researcher is central to this process.

The first question was inspired by my work hosting a talk show called 'Speak Your Mind' on Ruach Radio – a 24/7 Christian-centred station. The topics focused on

mental health and the first question posed to every guest was: 'What is mental health?' I received very interesting responses and thought it would be useful to learn how black individuals defined this term. The formulation of the other six questions was influenced by responses within the group settings. I simply wanted individual interview participants to expand on themes and ideas mentioned previously in the groups. The questions also sought to explore culture and wider socio-economic political issues, barriers to engaging therapeutic support and expectations of the church. It was also important to receive feedback on the experience of the groups, as a way of reviewing and providing useful information possibly for future research.

The Individual Interview Research Questions

- 1. In your opinion, what is mental health?**
- 2. How does your faith impact your health and mental well-being? And in what way does church attendance affect your health and mental well-being?**
- 3. Why do you think so many black people attend a church in the UK?**
- 4. Why do you think so many black people are in the mental health system in the UK?**
- 5. What help and support from the church would you find useful if you were experiencing mental health difficulties?**
- 6. How would you cope with a therapist or other service providers who did not acknowledge factors that are important to you such as faith or race?**
- 7. What was the group interview experience like for you?**

Before embarking on recruitment of participants, the relevant paperwork was submitted for ethical approval which was granted by the Metanoia and Middlesex Research Ethics Committee.

3.2 Ethical Considerations and Administration

(See Appendix 9: Ethical Approval Form)

The nature of the study meant stringent steps were employed to ensure participants were well informed before they were interviewed. All participants received comprehensive briefing sheets introducing the project and providing essential information, enabling them to make an informed choice. Great lengths were taken to ensure participants would be kept safe throughout the process and all willing parties were asked to carefully read and sign several forms signifying they understood: the purpose of the study, what was expected of them as a research participant, confidentiality, their right to withdraw at any time with no repercussions, what to expect of the researcher, what would happen to personal information, data protection, consent form and outcomes of the study. Participants were asked to identify someone they might speak to if the interview caused any triggers or emotional distress, details of psychological support was also provided with the information sheets.

Initially, anyone wanting to take part in the study was asked to register their interest at a dedicated email address. This was acknowledged with an introductory letter explaining the purpose of the study and the interview process. There were particular criteria clients had to fulfil such as being 18 or over, black, and a practising Christian.

(See Appendix 10: Participant Letter of Invitation)

It was imperative to work within Ethical Guidelines as directed by Metanoia Institute and Middlesex University. Guidelines and templates were followed closely and risk assessments conducted to ensure the safety of both researcher and participants. For example, making someone aware where I was going and what time I was expected to return. Pre-meetings were scheduled with participants to discuss any concerns about the study, as well as debriefing sessions after each interview in case there were any questions or comments. In addition, participants could give feedback on their experience in the focus group.

I was aware of the possibility that poor treatment of vulnerable congregants could come to light during the interview process. The confidentiality clause in the briefing sheets gave clear details of what steps would be taken should a participant disclose sensitive information, including discussing the matter with a clinical supervisor, critical friend or Academic Advisor.

Once participants agreed to be interviewed, and after reading, signing and returning all participant documentation, a choice of interview dates and times were disseminated. Participants also had the option of hosting the focus group at their own church or a neutral location, at a date and time of their choosing. Reminders were also sent out via email a couple of days before the interview date. Typically, this part of the process took a while to complete, requiring significant energy, flexibility and compromise; at times it was very frustrating.

The process of recruiting participants, organising and facilitating interviews took a year. In order to facilitate the groups, I had to be very creative. In reality the data-collection stage proved a very challenging part of the process and this is discussed in the next section.

3.3 Participant Recruitment

As a sole researcher with limited resources, a combination of approaches was used to recruit participants. Purposive sampling refers to the recruitment of individuals who are relevant to the research question and was certainly employed at this stage. In addition, voluntary and convenience sampling was used (Blaxter et.al. 2010); as recruitment involved intentional or targeted recruitment of a specific group of people. Convenience sampling is appropriate when restrictions are placed on the researcher, such as when members of an organisation select interviewees rather than give the researcher free rein to do so (Bryman 2008). In addition, snowball techniques were used also which rely on social contact between individuals to trace additional respondents (Beardsworth and Keil 1992).

Churches and church leaders in the London area were selected from The Directory of Black Majority Churches UK, ensuring a broad geographical area was covered and an equal number of leaders were included from across the capital encompassing North, East, South and the West parts of London. Pastors and church leaders were contacted by letter and invited to take part in the study and/or gave permission to access congregants who might want to participate in a focus group. Leaders were given a cut-off date by which to respond. A follow up email was also sent as a prompt to non-responders and a to those who did reply a 'thank you' email with further instructions was sent out.

(See Appendix 11: Participant Information Sheets).

Pastors and leaders had a pivotal role as 'gatekeepers' in the study, and were hugely influential in allowing me, an outsider, into their churches, gaining access to their 'flock.' It was important for me to appear non-threatening, to make it clear I was not representing any official, statutory, public agency, government body or had any type of agenda, other than to discuss mental health. I reassured leaders of my position as a committed Christian and that I was in a leadership position within a church, so had a degree of empathy and insider knowledge of the workings of the church. Despite my efforts, it became very clear early on, that this process was going to prove more challenging than I had anticipated. It became evident when I attended a 'Faith in Communities' event in Lambeth, where I introduced my research study and was actively inviting pastors and/or their congregants to participate in the study; a wide representation of black churches was present, but there was very little take up.

After sharing a summary of the project, I returned to my table where I was promoting counselling in churches. Several pastors and community officials including personnel from the police service and community care approached me to talk about black mental health. Several black pastors were very reluctant to discuss mental health and some said *it wasn't something their church would be interested in learning more about*. Some pastors expressed that mental health was a difficult and sensitive area and they did not want to engage. When I offered to meet with them and/or someone else from their church, the invitation was rejected. Some pastors expressed support for the study, stating it was an important area of research, but this sentiment was echoed primarily from church members, a few of whom shared their stories of mental health difficulties in the church. A number of individuals and leaders took copies of

the letter and information sheet I designed, a couple agreed to further conversations and I received two tentative invitations to come and speak to church groups about the study, which did take place. The follow-up calls to pastors yielded limited results. We discussed why I was doing the study, the research questions and aim of the study. The incentive offered for taking part in the study was free training. The ideal scenario would have been to have a selection of congregants from a church, and to hold the focus group at the church premises, or if the church was part of a larger network, a cross-section of individuals would come together to create a group which would be hosted at one of the churches, or participants could suggest a suitable place of their choosing. I wanted the process to be as easy as possible for participants by minimising the need to travel long distances; it felt important for the meetings to take place in familiar settings, where possible.

I was fortunate enough to have the support of my employers, Goldsmiths, University of London, who felt the project had relevance to the large multicultural student population, some of whom held strong religious beliefs. I was permitted to utilise a space within the counselling service to host focus groups, which was a huge help.

A couple of senior pastors requested to meet with me to discuss the study, and a number of pastors passed the research information on to other members of the church who contacted me to organise focus groups. Overall, I received very little interest from pastors, but a small number did agree to be interviewed. I realised I needed a different approach; I had to be more creative in my recruitment drive if I was to meet my target of a hundred participants.

I became somewhat of an opportunist, capitalising on every occasion to talk about my project and to recruit participants. I contacted Dr Joe Aldred, Bishop, author and member of Pentecostal and Multicultural Relations Churches Together in England, for advice on how best to approach Pentecostal pastors. He directed me to the Black and Multicultural Churches Directory and suggested I contact pastors directly. Independent Charismatic and African Pentecostal churches were contacted directly, local historic churches that had black majority membership were also approached. A local priest invited me to meet with members of his congregation, some of whom were white. I met with a number of individuals who were gathering for a tea and coffee morning, one of the support mechanisms put in place to help manage their mental health difficulties. The priest mentioned the majority of congregants came from non-British backgrounds. I met with a number of the black attendees, but their mental health difficulties were so severe it was difficult to maintain conversations. Consequently, it was not possible to facilitate a focus group with these congregants, many of whom had long and enduring mental health problems and were on long-term medication; attending the church for coffee mornings seemed to be an important part of their week. The individuals spoke positively about the church. It was a disappointing outcome, but I quickly sought the next opportunity, hoping it would be more fruitful.

Other organisations approached for the purposes of recruitment included: the Christian Union at the university where I was working at the time; the Spirituality and Mental Health Forum hosted by Psychiatry Special interest Group on Spirituality (PSIGS) which I attended regularly; the Black and Asian Therapy network (BAATN); South London and Maudsley, Juney Mohamed was commissioned to deliver mental health awareness training to Pastors in South London, who provide useful pointers such as offering free events; South East Therapy Forum, of which I was founder and

chair, representatives from hospitals, universities, training institutes and charities such as Mind were members who helped to disseminate information and promote the study; Churches Together England; Faith Action the national network that offers training, funding, advice, an appeal for participants was made on The 'Speak Your Mind' Show on Ruach Radio, as well as other online organisations such as Keep the Faith Network and Faiths Together in Lambeth.

I enlisted the help of insider assistants some of whom contacted me directly; these were individuals who attended BMCs who advocated on my behalf, speaking to leadership teams, and/or recruiting participants and organising suitable spaces for focus groups. I mobilised the help of friends who attended BMCs, encouraging them to approach their leaders to agree to host a focus group at their church. Whenever I attended church conferences, facilitated workshops or delivered training, I seized the opportunity to speak about the study and invite individuals to participate in a focus group. I also approached networks of churches which are clusters of churches/ leaders who support each other and host joint events. Where possible I approached some pastors in person, then made contact by letter and a follow-up email. On several occasions I had telephone conversations with pastors, often I was met with reservation, especially after sharing the questions.

Over two hundred churches were approached encompassing all denominations including: Pentecostal (Apostolic and Trinitarian), Charismatic, Evangelical, African Pentecostal churches, Sabbatarians, New churches, independent churches, historical churches and Catholics.

Encouragingly, I was also contacted by black Christians who had heard about the study from as far afield as Sheffield, Birmingham and Wiltshire. Individuals wanted to contribute to the study. Consequently, I travelled across the country to host focus groups. I also received several emails and messages from individuals expressing their interest and support for the study which was very uplifting.

3.3.1 Description of Participants

Collecting demographic information aided in contextualising people's responses. The participants came from a broad range of socio-economic backgrounds, age ranges of between 24–86 years, significantly more women than men took part and more single than married people were represented in the study. Although a large percentage of participants had not experienced any mental health difficulties, a significant number of participants declined to respond to the question: 'Do you, or have you ever had mental health difficulties?'. A majority of participants had been a Christian for over 40 years or 'all my life'. Most participants chose to describe their church as Pentecostal although all types of BMCs were represented in the study.

(See Appendices 13-16 for Participant Information Forms)

(See Appendix 17: Focus Group Script)

(See Appendix 18 for Participants' Demographic Information)

3.4 Summary of Focus Group Process

Of the one hundred and five individuals who registered to take part in the study, fifty-six attended interviews. Apart from a few apologies due to unforeseen circumstances, it is unknown why the majority of the forty-four prospective participants did not attend.

Eleven focus groups and eight individual interviews were conducted. Originally, the aim was to facilitate ten focus groups; the eleventh group came about when I was contacted by an insider helper whose pastor had agreed to the running of a focus group. The insider had recruited participants from several different churches, secured the space at her church, and arranged the time and date of the interview. With such commitment and so little effort needed on my part, I was delighted to hold another group.

The process of facilitating focus groups is akin to organising counselling sessions. Sometimes the client cancels at the last minute, or they arrive late, or they don't arrive at all. Rebooking a client is sometimes required, sometimes the client withdraws from therapy with no communication and sometimes they disappear and re-emerge later on. Consequently, on occasion split decisions were made as to how long I would wait for latecomers before starting the interview. Normally I would commence the interview after waiting ten minutes, to ensure there would be enough time to get through the questions without rushing. Late arrivals were managed by the research assistant. Participants who attended were given the option as to whether the interview should go ahead or not when fellow participants did not show and/or the group numbers were low. In all cases participants agreed to continue with the interview. Participants were encouraged to be open about their views, and that differing opinions were welcomed as this would add further richness to the study. Where the questions were long and/or had several parts to them, for example, questions 4 and 5, each part of the question was tackled separately.

The use of different venues may be significant and could have some bearing on the overall outcome of the interview groups; any negative impact is not immediately obvious to me. Sessions were held across London, the South East and South West of England with participants travelling from Yorkshire, the Midlands, Bedfordshire, Wiltshire and the South East to take part in the study.

Group Number	Location Where Focus Group Took Place
1, 2, 5, 7, 9	Goldsmiths, University of London
6, 10	Participant's Home
8	Community Centre
3, 4, 11	Church Setting

Table 1. Focus Group Venues

3.4.1 Research Assistant

I secured the help of a research assistant; she was a qualified therapist and Christian who had expressed an interest in the research area. After committing to confidentiality and data protection guidelines, she undertook administrative duties and was responsible for: helping set up the space prior to interview, welcoming participants as they arrived, covered health and safety and ensured all relevant forms were completed and submitted and created name tags. Her efficient approach meant she was very organised and that participants were able relax in a calm environment before the start of the interviews.

Once the interview was underway her role involved scribing; she made written notes of emerging themes and patterns, interesting comments or reactions to questions

and made mention of any underlying/unconscious processes. This enabled me, as the researcher to set up the recording instrument, prepare myself psychologically, manage time and to direct my focus to the interviewing process, asking the questions, observing body language, listening to responses and using these to generate subsequent questions and discussion. At the end of the interview the research assistant summarised her observations, giving the group brief feedback on the most prominent themes. The assistant and I would debrief after all the participants had left, providing her the opportunity to share any additional feedback on impact, content or process of the focus group. Her notes were then securely stored alongside the other participant documentation.

3.4.2 Participant Data Collection: Focus Group Interviews

(Appendix 17: Focus Group Script)

Efforts were made to conduct each group in a uniform way to ensure consistency, reliability and fairness, regardless of venue. A set pattern was followed for introducing the group discussion with a clear beginning and ending, also recommended by Kruger and Casey (2000): 1. the welcome, 2. the overview of the topic, 3. the ground rules, 4. The first question. I also included additional points, 5. any questions arising from the information sheet or instructions given? 6. Participants were directed to be conversational in their approach and could respond freely to each other's comments, to avoid being domineering allowing everyone space to contribute, 7. Participants were reminded that the session was being audio recorded and excessive noise should be kept to a minimum.

The interviews were captured using a digital audio recording device, which was tested and re-tested before each interview. Bryman (2008) notes qualitative research is not just about what people say but also in the way in which that they say it. The recording then allows for the complete account of the series of exchanges in an interview to be available. Qualitative pays attention to language and the recording of conversations therefore is essential. In the study a second recording device was used as a back-up.

Heritage (1984) highlights the advantages of recording and transcribing interviews:

- It helps to correct the natural limitations of our memories, and of the intuitive glosses that we might place on what people say in interview;
- It allows more thorough examination of what people say;
- It permits repeated examinations of the interviewees' answers;
- It opens up the data to public scrutiny by other researchers, who can evaluate the analysis that is carried out by the original researchers of that data (that is, a secondary analysis);
- It therefore helps to counter accusations that an analysis might have been influenced by the researcher's values or biases.

Each research question was put to the focus groups and additional prompts inserted where necessary. When the conversation came to a natural lull or the group was moving into another area I would intervene with the next question. The focus group sessions were up to 1.5 hours in duration, normally this was sufficient and allowed enough time for everyone who wanted to, to respond to the questions. You will see that some groups were very small and therefore some sessions concluded in an hour. It was important to be flexible in relation to each group, to pay close attention for example, to the level of engagement, the mood of the groups, the tone of

responses, the rhythm of the group, and to respond accordingly in order to keep the momentum going.

Each group experience was different; however, there were some similarities I wish to highlight: the questions generated healthy discussions, everyone within the groups participated, there were differences of opinion, something interesting emerged, individuals were very open and shared their stories, someone said something profound, I had to maintain strong boundaries to ensure all questions were asked within the allotted time and that the session ended promptly because participants were so engaged.

I was aware of my 'insider researcher' position; an insider because of my knowledge and personal experience of BMCs, the mental health system and psychotherapeutic services. As researcher, I am still exploring and examining, I am open to learning and hearing different perspectives, as well as stories similar to my own. Going into each interview I positioned myself to be 'curious' and did not have any preconceived ideas as to what might happen. I was conscious of not wanting to 'lead' interviewees, I relied on counselling skills such as paraphrasing and summarising and listening skills to remain 'participant-focused.' I managed this by not sharing any personal experiences and using the words and material of the speakers to generate further questions. It is not always easy to achieve – no intrusion of our own biases and expectations but maintaining focus is important (Bryman 2008).

Kvale (1996) in Bryman (2008: 445) proposed a list of ten criteria of a successful interviewer, many of which I incorporated when conducting the interviews:

- *Knowledgeable*: is thoroughly familiar with the focus of the interview;
- *Structuring*: gives purpose for interview; ask whether interviewees have questions;
- *Clear*: asks simple, easy, short questions; no jargon;
- *Gentle*: allows people to finish; gives them time to think; tolerates pauses;
- *Sensitive*: listens attentively to what is said and how it is said; is empathetic in dealing with the interviewees;
- *Open*, responds to what is important to interviewees and is flexible;
- *Steering* – Knows what he or she wants to find out;
- *Critical*: is prepared to challenge what is said, for example inconsistencies;
- *Remembering*: relates to what is said to what has previously been said;
- *Interpreting*: clarifies and extends meanings of interviewees' statements, but without imposing meaning on them;
- *Balanced*: doesn't talk too much (Bryman 2008);
- *Ethically sensitive*: is sensitive to the ethical dimension of interviewing for example, purpose and confidentiality (Bryman 2008).

(See Appendix 18: Participants' Demographic Information)

3.4.2.1 Overview of Focus Groups

A brief summary of my experience of the eleven interview groups will follow, highlighting outstanding and memorable features unique to each one. A more detailed description of the groups will be given in chapter four.

Group 1 left me feeling excited and affirmed. The discussion was so vibrant, the participants so engaged, my input was only needed to ask the questions. This group was very psychologically aware, fluid, with abundant energy and empathy.

Group 2: Unfortunately, several group members did not show, and one member was late. This should have been a group of six but only two members attended. The participants took the decision to go ahead with the interview. The male and female interviewees came from very different positions in their conversations and more will be said about what emerged from this group in chapter five.

Group 3 consisted of Catholics who all attended the same church, and the interview was conducted at the church. This group was the largest but not the most talkative. Overall, this group required more prompting and follow-up questions than other groups, not everyone chose to respond to the questions, and when they did the responses were very concise. A possible explanation could be that this group contained the highest number of retired individuals and represented some of the oldest participants in the study. We had fun and laughter in this group; there were a number of memorable speakers.

Group 4: All members came from the same church, some of whom had known each other for some time, the group was held at their church. This too was an engaging group made up almost entirely of professionals. There were lively conversations and moving personal reflections and stories.

Group 5: A number of participants cancelled at the last moment, three attendees were given the option and agreed to go ahead with the interview. Two women and one man really utilised the time to give lengthy responses to the questions, and seemed to very much bounce off each other which kept the flow of the conversation going. They were all strong characters, with equally strong opinions; this set the tone for a very lively and enlightened interview.

Group 6 came about after a participant in an earlier group contacted other friends and mobilised them to form a focus group. The group took place at the home of one of the participants. The two females and one male had strong opinions and very different interpretations of the research questions, which added further dynamics and debate to the interview experience. The views of the male participant were contentious at times, which stirred the discussion even further.

Group 7: A number of participants failed to show up for this session also. The individuals present decided to be interviewed once the third person had arrived. Two members had come from the same church and had very strong views about causative factors of mental health and how to manage it. This, although at times controversial, added a diverse perspective to the research questions and overall discussion.

Group 8 consisted of seven individuals who had, or who were currently experiencing severe mental health difficulties. A staff member with an interest in the research area also joined the group. The group took place at a family community centre in South London. The social model was being utilised here with attendees receiving holistic support from the staff team. I was very touched by this group, and experienced a

range of emotions from pride to sadness, anger to hope and found the participants to be hugely inspirational; they seemed to embody everything that motivated me to do this study.

Group 9: Prospective participants simply did not show for this session apart from two females. This interview therefore became very much a conversation, but the women were heavily involved in ministry within their church, and were in leadership positions and had much to say on the issue of mental health. They shared a new initiative they had implemented in their church to manage mental health issues (twenty-minute talks on a mental health-related topic after Sunday service). Between them they were very proactive, forward-thinking and engaging.

Group 10 was a group of professional women who had attended the same church for many years prior, and who came together from different parts of the country to form a focus group held in the South West. The emphasis from this group was on professionalism and between them they made numerous suggestions as to how mental health could be tackled in the church.

Group 11 was established by an insider assistant who spoke with her pastor about the study, and after his approval, brought people together from her various friendship groups, many of whom didn't know each other. Despite one person not attending this was a fascinating group who shared a wide range of experiences and painful stories, and were very open about the impact of these experiences in their churches.

3.5 Summary of Individual Interview Process

(See Appendix 18: Participants' Demographic Information)

A number of individuals within the focus groups stood out for different reasons. They: held strong and compelling views or had a unique perspective; had interesting or unusual things to say; were particularly knowledgeable on a certain aspect of the topic or it was felt they would add another dimension or further depth to the data. These individuals were invited to take part in individual interviews. Participants' availability was also a deciding factor as to whether they could attend an interview.

Individuals who could take part underwent a similar process to that of the focus groups. They completed and signed relevant documents, indicating they understood the process and that they could withdraw from the study at any time. Two participants who could not attend a focus group interview due to circumstances, volunteered themselves to take part in the individual interviews.

During the focus group phase, questions were beginning to emerge for the next stage – the individual interviews. As the focus groups came to an end, the individual interview questions had been formulated. They were developed from the group discussions and it was hoped they would bring further breadth and insight to the research.

3.5.1 Participant Data Collection: Individual Interviews

A similar approach to the focus groups was employed in relation to the individual interviews. Each candidate was read a short script introducing the topic and outlining what would take place throughout the interview process, including how many

questions, what would happen if they did not wish to answer a question or if they wished to withdraw.

There were eight candidates, two of which were men and five were female. Their ages ranged between 31–57 years and candidates came from diverse socio-economic backgrounds and BMCs. The period given to complete the individual interviews was three months, it in fact took four months.

Taking into account client availability, distance, time and resources several approaches were taken to facilitate data collection: face-to-face, telephone and online interviews via email. A number of participants did not feel comfortable speaking in person or over the phone and opted to respond to the questions in written format. Although this meant diversifying the data collection method, it was felt the emphasis should firmly be on data generation. So rather than be too rigid regarding how the data was collated, it felt far more important to be flexible and accommodating to acquire the data however possible, taking into account each participant's preference.

Utilising telephone interviews has been the subject of some studies. One example showed there was no noticeable difference between the responses given in face-to-face and telephone interviews, they were similar in quantity, nature and depth (Sturges and Hanrahan 2004). However, Bryman (2008) cautions that telephone interviews will not work well with long interviews, that it is easier for participants to terminate the interview than in person, that it is not possible to observe body language and facial expressions in response to the questions.

A variety of venues were also utilised. They were all private, quiet, appropriate spaces to protect confidentiality, to minimise interruption and to allow for audio recording with low to no risk of disruption. Each interview was up to one hour in duration, followed by a short debrief to allow participants the opportunity to share thoughts and feelings about the experience, and to comment on any part of the process. Alternatively, they were also invited to provide feedback via email if they preferred.

It was not necessary for the research assistant to be present during the individual interviews. As researcher I conducted the interviews in a similar vein to that of a counselling session; a client/participant-centred approach, noting significant points, reflecting back and moving the discussion on, within an allotted time frame.

Reflections

Facilitating the group and individual interviews was a real honour. To engage with so many different people, who in different ways 'added to me', it was an amazing experience. I felt myself growing as a researcher and my confidence and belief in the project rising. At the end of every interview I would thank participants for their contributions and on each occasion, someone would begin to thank me for undertaking the study, stressing it was much-needed area of research. As a 'thank you' I felt I owed it to the participants, to those inpatients on the psychiatric wards twenty years ago, to current sufferers of mental health problems, specifically black Christians, to do something meaningful with the project at the end of the process. I was totally convinced, convicted with an even greater resolve, that this project should achieve its goal; it would make a difference to the lives of black Christians in the UK.

4. Data Analysis

(See Appendix 19: Participants' Transcript Checking Instructions)

Once the focus group and individual interviews were complete, the recordings were downloaded onto a computer and memory stick and the interviews transcribed verbatim. The written texts reproduced exactly what interviewees said word for word. Portions of the recording which were unclear or inaudible were highlighted, rather than me guessing what the interviewee might have said or meant, they were sent to the participants for clarification.

4.1 Transcription Process

Due to a change in circumstances the transcriber could not complete all the interviews, so I undertook the task of transcribing all the interviews bar two focus groups. As is so often written about by seasoned researchers, I underestimated the time needed to transcribe the interviews; I anticipated ten months, the process took almost 18 months. Even though I started transcribing before the interview process was fully complete, vast amounts of time and energy were required. The sheer amount of data this process produced was overwhelming, and required efficient administrative systems to remain organised and to minimise chaos and stress.

When the transcribing process was complete each participant received a copy of their group's transcript to: check for accuracy, make any changes, add comments, clarify, as well as have the option to withdraw part or all their verbal account.

Participants were reassured that they were not expected to remember everything they had said during the interview given how much time had passed, but simply to judge whether the essence of what they were trying to say had been captured. For

the purposes of quality control, and to ensure participants were included in all the key stages of the project, this part of the process was very important. The ability to capture participants' words as close to the original as possible, helped to engender a true reflection of the accounts. Participants were specifically directed to sections highlighted as inaudible or unclear in the text and were given a deadline by which to return comments, changes, feedback or queries. A couple of participants responded and the necessary adjustments were made to the text.

Although a hugely labour-intensive exercise, the transcribing process enabled me to immerse myself in the data. The task of reading and rereading the interviews meant I became increasingly familiar with the text and was more able to see emerging themes and patterns.

4.2 Thematic Analysis

Thematic Analysis (TA) is the method I used to analyse the qualitative data. The widely used version was developed by Virginia Braun and Victoria Clarke (2006). Boyatzis (1998) was an earlier writer in the field. TA known for its flexibility, can be used to address most types of qualitative research questions, works with most types of qualitative data, including focus groups and interview data and can be used across the spectrum of theoretical approaches used in qualitative research (Vossler and Moller 2015). It is a method for identifying, analysing and reporting patterns within data and across the dataset. The most important aspect of data collection is the quality of the data. Terry et.al. (2017), describe rich and complex data on a given topic are the crown jewels of qualitative research allowing us deep and nuanced insight. The researcher has an active role in identifying these patterns or themes, selecting which ones are of interest. A theme captures something important about

the data in relation to the research question and represents a level of patterned response or meaning within the data (Braun and Clarke 2006).

TA is suitable for those who want to engage in research around experiences and understandings as well as practices and behaviours and requires the researcher to reflect upon their part in the process of data analysis (Hayfield 2017). The analysis is seen as something created by the researcher. Terry et.al. (2017) assert good coding is open and inclusive, there are no 'right' or 'wrong' codes; codes generated need to be meaningful to the researcher, capturing their interpretation of the data in relation to their research questions.

Braun and Clarke (2006) produced a six-phase approach to TA: 1 Familiarisation with the data: reading and re-reading; 2. Generating Codes: generating succinct labels that identify important features of the data relevant to answering the research question; 3. Constructing themes: examining the codes and collated data to identify significant broader patterns of meaning; 4. Reviewing potential themes: checking the candidate themes against the data set, to determine whether they tell a convincing story that answers the research question; 5. Defining and naming themes: developing detailed analysis of each theme; 6. Producing the report: writing up, weaving together the analytic narrative and data extracts.

When utilising TA it is necessary, as the researcher, to be clear about the theoretical approach, and to make a number of choices. There are two basic approaches to TA: 1) Deductive or 'top-down way' – themes/analysis is guided by pre-existing theoretical concepts or analytic ideas, separate from the data themselves. It tends to be driven by the researcher's theoretical or analytical interest in the area and is

therefore more researcher-driven; 2) Inductive or ‘bottom-up way’ – analysis driven by, and reflective of, the content of the data. The analysis is data-driven, it is a process of coding the data without trying to fit it into a pre-existing coding frame (Vossler and Moller 2015).

Another decision to make revolves around semantic or latent themes. With a semantic approach analysis captures meanings that are explicitly stated in the data, so the words are taken at face value. Conversely, latent analysis captures meanings not explicitly stated in the data, including the ideas, assumptions or concepts that underpin what is explicitly stated, and as Terry et.al. (2017) point out this approach involves interpretative work.

The final decision to be made is whether analyses should be more Essentialist or Constructionist. Essentialist analyses assumes that there are fixed qualities ‘inside’ people (essences) such as personality, that result in the experiences and interpretations that people report. On the other hand, Constructionist analysis is conducted within a framework that does not assume essence, or a single reality, but rather theories, multiple realities, produced (constructed) through language, representation and other social processes. These are still, experienced as true and real by people (Vossler and Moller 2015).

Regarding this project the research questions are experience-type questions; the ontological framework is critical realism – reality is ‘out there’ but access to it is always mediated by socio-cultural meanings; people’s words provide access to their particular version of reality; and the epistemological framework is contextualism, an approach that assumes meaning is related to the context in which it is produced. The

TA approach used was inductive which means coding and analysis were primarily at the semantic and essentialist levels. These choices reflect that the aim of the research was to identify patterns in what black Christians said about their experiences of mental health and management of mental health within BMCs, and the wish to stay close to how participants made sense of their experiences.

4.2.1 Narrative Analysis

Narrative Analysis (NA) argues ‘everything is narrative’ – that people make sense of their experiences through telling stories. NA analyses stories using various analytic strategies – usually constructivist/interpretivist in orientation (Vossler and Moller 2015). With NA the focus of attention shifts from: ‘What actually happened?’ to: ‘How do people make sense of what happened?’ Bryman (2008), argues there are two distinct ways of thinking about NA: firstly, it is an approach to analysing different kinds of data such as interviews; secondly, the researcher deliberately seeks to stimulate the telling of stories. There is some criticism of this approach. Some narrative researchers treat stories they are told uncritically, and regarding some studies of NA in organisations, there are questions as to what is it that such studies reveal? How far do the studies reflect underlying ‘truth’ about what happens or how far they reflect the divergent perspectives of different groups? (ibid).

It was anticipated that participants would resort to expressing themselves through stories and vignettes. It stands to reason that as Pentecostal Christianity has survived centuries due to its oral tradition alongside cultural dimensions, that Black Christians would choose to share their experiences in a similar way during interview.

Due to the sheer volume of data generated from interviews, it was necessary, for the sake of time and resources, to utilise computer-assisted qualitative data analysis software (CAQDAS), to aid in storage, coding and analysis of the data, working alongside the manual approach.

4.3 Working with NVivo

The interviews were transcribed verbatim and NVivo was used to code the transcripts and identify emerging and relevant themes. NVIVO, was the chosen package for a number of reasons: according to Barnes (2008) this programme involves the process of indexing all the transcripts, in order to group together all the pieces of data that correspond to a certain category or theme; it supports the code-and-retrieve of data; it takes over the manual task of coding, cuts and pastes chunks of text relating to specific codes and classifications, and stores data in organised and accessible folders. However, it is still the responsibility of the researcher to interpret, code and retrieve the data but the computer simply takes over the manual labour (Bryman 2008).

One of my greatest challenges was learning NVivo whilst managing and coding the data at the same time. It took a while to get to grips with the software package and involved hours of watching tutorials and reading instruction manuals. Although learning NVivo on the job was time consuming, especially the coding phase, it was a welcomed time saver in the long-term; for example, all relevant interview excerpts relating to a specific topic or themes were stored in one place and were easily accessible, and of course the obvious advantage of familiarisation with the data. The disadvantages of using CAQDAS are the danger of becoming detached from the

findings and missing some of the less immediately obvious themes that come out of interviews, such as contradictions (Bryman 2008).

The use of NVivo involves importing the interview transcripts into the programme, once this occurs, they can be read and edited. The data is then coded, accomplished through nodes. Coding is described as the process of marking passages of texts in a project's documents with nodes. Nodes are the routes by which coding is undertaken. Bryman (2008) defines a node as a collection of references about a specific theme, place or person or other area of interest. When a document has been coded, the node will incorporate references to those portions of documents in which the code appears. Nodes can be changed or deleted and can take on different forms. There are tree nodes or tree-like hierarchies which show connections between nodes and independent or free nodes. The programme has certain in-built features which assist in data analysis such as coloured coding stripes that represent portions of coded text and the nodes that have been used, and word frequency functions.

In all, the eleven focus groups and eight individual interviews equated to almost twenty-five hours of recorded material. Once the material was transcribed and imported into the software package, NVivo helped organise the data by creating structure and clustering of ideas and patterns which were eventually developed into meaningful themes. NVivo made it possible to develop different levels of data or subthemes without getting swamped or lost in the material, which in turn allowed for greater clarity and a better understanding of what was important across the dataset. NVivo played a critical role, however, it had its limitations. I was still required to manually import, code and manage the data. Overall a combined approach using both manual and software applications was used at data analysis stage.

The findings of the study will now be examined followed by a discussion of the results and further reflections.

5. Findings

5.1 Focus Group Themes

(Appendix 20: Original Codes/Nodes Focus Groups)

Almost two hundred and fifty codes were generated from the dataset using NVivo. These codes were further condensed into meaningful categories and key themes to address the research questions. Through immersing myself in the data, and repeatedly reading and rereading the transcripts, the original two hundred and thirty-three codes were reduced to fifteen main categories.

A summary of the findings will be followed by the main fifteen themes presented individually, illustrated by extracts from across the dataset. Contributions that were unusual, interesting or important in addressing the research questions will also be incorporated. Attention will be given to excerpts which support or challenge existing literature; they will be examined in greater detail in the discussions section. Additional notes are added in brackets to aid understanding where necessary. Participants' identities have been changed to protect anonymity.

5.2 Summary of Findings

Overall, participants spoke clearly and openly about how important **faith** was to them, regardless of whether they had experienced mental health difficulties or not. How long a person had been a Christian did not appear to alter the results greatly, with 33 per cent of participants identifying as Christian for 30 years or more and 2 per cent for 5 years or less. Generally, faith communities presented a number of

challenges but faith was considered a good thing, especially during difficult periods; Christianity was a choice and a lifestyle and this is echoed in the first excerpt:

Priscilla: We did it on Sunday, we sang that song, 'He'll do it Again' and that's how I think my faith really helps to... it's what's embedded, I think it just helps to kinda, you know, undergird and underpin. It just, it's, it's just marvellous, words I think sometimes doesn't explain it and express. We can't articulate it well enough but that's, it's like there's a hand that lifts you up when you need it most, you know.

Kate: I get great comfort and great strength from my faith, church is very important to me.

Yasmin: ...go to church and just sit there, and somewhere along the line in those one and a half or two hours usually three, something clicks and you feel better for that day, you feel better for that morning. But you feel better. Sometimes that affirmation, hearing that constant Word of God which is true, those words are alive. Thinking about the current situation, all that is written a thousand years ago. It's real.

Of equal importance was being in the 'right' church. Participants spoke of the 'culture' within some churches for example, controlling and unfriendly. As a consequence, a small number of interviewees stopped attending church and were in transition with no permanent church home. Other participants articulated what they deemed as essential criteria of a successful church, but most tended to highlight

what they thought was 'wrong' with church, causing some to leave and find another church home, for example:

Barbara: And the thing is black churches, I mean it was a smallish church, but it was everyone knew everybody's business, almost like and everybody thought they had a say in your life, and they were qualified to tell you exactly what you should do ...yet everything they were telling you was not happening in their own house. So when, so when you start to realise this, all these people that you had so much faith in, you know, the whole thing it's devastating, and I walked away from it, you know.

Ethan: ...because mum she goes Catholic church, when I used to go with her as a teenager I used to be bucking [nodding off] [laughter], the priest's boring me. He's talking from a book he aint telling me nothing that's resonating. I went to my cousin's sons umm confirmation...yeh preacher's talking, he aint saying nothing that is like what's going on outside the church walls and that's just me. Other people they enjoy it, they feel something off it, they get food off it, I don't.

Recognising the failings of the church past or present did not deter participants from attending services. Participants acknowledged church leaders are subject to human error and poor judgement, making mistakes more tolerable. Often the **benefits of**

church seem to outweigh or override the less favourable parts. Church seemed to have a 'pull'. Here one participant offers an explanation:

Christine: But then the middle-aged people there's nothing for that kinda age...Do we look at their prospect in life? What they're doing? We don't do anything like...Yeh, other than the young people, the older people will take care of them. And that's that, yeh so the middle, in between, you're left to sort yourself out...yes I do, the spiritual side, I enjoy going [to church] although I don't go regular enough ...but when I do go, I like the worship and I like to hear the Word of God and I do enjoy that, yeh.

Researcher: So, it serves a purpose, from what I'm hearing today however, the practical side is where the church needs to do more work.

All: Yeh, yeh.

'Reaction to distress'. This code encompassed interpretation of problems, behavioural, psychological and social responses to distress. This area elicited the highest number of responses across the dataset. Participants went into detail about how they reacted to problems and what mechanisms were most effective in managing emotional and psychological impact. Participants across the dataset engaged in a wide range of activities in times of distress, as illustrated by Frank:

I go to the gym, jogging, exercise, love that. Love good action

films, chilling, and I'll lose myself within the film and be a part of it and become an actor for a moment. And, umm, basically, of course I draw on my faith, a lot of prayer, a lot of praise, a lot of worship, a lot of dancing...

Another significant observation across the dataset was the importance of being **self-reliant**. Participants spoke of managing problems themselves; alone or in isolation finding their own solutions, despite being part of a wider church community and having family and friends. Participants gave a variety of reasons as to why this was the case, for example:

Susan: ...sometimes in life you're not in a position to call P2, P4 and I think that is when you can really look to your faith to say, OK, I need some help here, or some guidance. Sometimes there's nobody else to help you through what you need to go through, you have to do it on your own.

Abigail: ...but there are some times when the Lord makes it clear it's Me you need right now, shut everything off... and He will show us certain things either to go and deal with it, or show us so we can address it ourselves...Can I say just one thing. I understand you saying alone time being a defence mechanism and it's come about because of not having anyone there, and I think in some cases that might be true; but I think, umm as I've grown and developed and know myself, it's not a defence mechanism it's a time of nurturing, it's a time where I feed myself and I water myself and I listen to myself,

and it helps me to make, you know, like you said, quality decisions about stuff because sometimes you don't need other voices...

A distinction should be made regarding 'alone time'; alone time can be protective and nurturing, but when it is driven by fear of speaking out, an unwillingness to ask for help or leads to isolation, mental health issues can arise.

'Church culture' elicited the second highest response rate across the dataset, participants defined this in several ways. Church culture is akin to any organisational culture; essentially, it is the institution's systems, structures or way of conducting itself and includes the 'atmosphere', explicit and implicit rules and expectations. The Bible and interpretation of scripture are similar to the mission statement and operational policies and procedures of an organisation which determine acceptable and unacceptable behaviour, specific practices, lifestyle, beliefs and so on. Each church has its own culture, as do the denominations in which the individual churches sit. Church culture defines what is acceptable or unacceptable as described below:

Gina: I feel as though there's too many people who are supposed to be Christians who judge you.

Elsa: Smoking, drinking, yeh those are temporal things and I understand you know, but things like the clothes you wear is a sin and it's just modesty that should be the issue. So basically, it causes you to think Oh! Now I don't go to the church that I grew up in because I think they're so many restrictions and you think it doesn't matter. If you're wearing earrings, that doesn't change

what's in your heart, so it's all those things they impose on you, you cannot wear earrings, you cannot wear jewellery, you know.

Cara ...I did go to another church...black charismatic [sigh], bigger because...I wasn't looking for relationship again, I didn't want to be steeped in politics again... there was a certain culture...as a newcomer, you were expected to fall in line..

Donna: ...sometimes you go to a church...you might not fit in with the clique and you might think 'Oh is there something a bit different about me?'

To meet the needs of their congregations, Pentecostal churches may need to reflect on current church culture and aim to foster an environment that is more respectful, relevant, open and nurturing.

Central to church infrastructure is the **leader/leadership**; their personalities, skill, and qualities which inevitably influence the growth, insight and awareness of the congregation. In addition, the size and 'business-likeness' of the church, reflects the type and range of interventions put in place to address social and psychological issues.

Of the Eight pastors who took part in the study six were senior leaders. The six senior pastors were informed, had awareness of mental health issues and had completed a variety of training courses to assist them in supporting church members.

However, they acknowledged the importance of working alongside other external agencies, as they did not always have the expertise to deal with more complex situations. They were receptive toward an interdisciplinary approach to addressing mental health distress in the church.

A further five senior pastors did not participate but actively supported the project through promoting the study, encouraging congregants to take part in focus groups, offering their church premises to host interviews and expressing how important they felt the project was both personally and for the wider church community.

This small sample of pastors does not appear to be representative of pastors within BMCs; it seems the majority of pastors, particularly the ones contacted for the study, were reluctant to engage with external services, did not see it necessary to discuss mental health or to undertake training.

This supports the work of Powell (2016) who noted pastors who had access to psycho-education were more likely to recognise and acknowledge bio-psychosocial causes and less likely to attribute mental health to other causes. Connecting with pastors is an ongoing challenge and will probably require much thought and help from insider assistants moving forward. It is clear that without pastors' input many congregations may remain less informed and churches less equipped to deal with mental health concerns when they arise, and problems will continue to be over-spiritualised and/or demonised.

Some leaders make themselves accountable to other leaders to decrease isolation and access support. Here one pastor speaks of her own experience at a time when she needed help:

Brenda: I approached my leader when I was going through my divorce,
he said 'I can't help you,' and, as a leader, I was expected to function
in my brokenness.

'Therapy' also stimulated a high volume of responses across the dataset, it incorporates experience, perception, availability and rejection of therapy. Therapy was discussed in all groups. Interpretation of problems and the level of self-reliance directly influenced whether therapy was even a consideration in times of difficulty. Culture and type of church were also determining factors, as the comments from Isabel and Ezekiel illustrate:

Isabel: ...going to confession is like going to a counsellor

Ezekiel: ...He (God) is my therapist

Participants appeared to be positioned along a continuum of either challenging the church at one end, or being protective or defensive of it at the other; the data showed a majority polarised around the former position; this was evident in discussions in all focus groups, illustrated in the excerpts below:

Brenda: I just wanted to say real quick that, umm, we have to remember there is a lot of responsibility placed on leaders' shoulders because for a lot of people they represent who God is

Researcher: So, what is happening in the churches now? What would you say helps members with their mental health and well-being?

Brenda: Honestly, I think there's very little if I'm being honest ... some churches do have counselling services, which is great, but we need more; umm also as well, our leaders need more training ...

Ezekial: What I wanna say is, you did say at the beginning it's OK to disagree ... My thing is, I can identify with a lot of what people are saying in the room ... but I'd like to really just end off on a umm I think the church is doing ... I think 'the harvest is plenty but the workers are few' [Matthew 9:37], and there are people there that have the skills umm and there's not enough of them and so they will put people in these positions to try help with the situation, but they don't necessarily have those skills, and when they don't have the skills we go to them and we find out ... Oh, what we need is not there as my sister was saying, we get hurt and we think church is rubbish ...

5.2.1 Participants' Responses in Relation to Demographic Information

(See Appendix 16: Participants' Personal Information Sheet)

Participants were asked to provide standard demographic information before taking part in the study. Interviewees were not obligated to complete any section on the form, but the majority did. Some general observations are presented below, taking into account marital status, gender, ethnicity, occupation and experience of mental health difficulties.

(See Appendix 18: Participants' Demographic Information)

Marital Status

The majority of participants were female and single, and this may have some bearing on the findings in relation to, the need to be self-reliant echoed throughout the interviews. Although not indicated in the table, almost half the male participants were married.

Gender

Gender differences were apparent regarding interpretation and management of problems. Moreover, there were some remarkable differences between the male participants in the study. Male participants tended to differentiate between coping strategies pre-conversion and strategies used post-conversion.

Ethnicity

Given that almost 60 per cent of participants were of Caribbean decent, this had some bearing on what was perceived as 'culture'. Caribbean culture and African culture are different, so the study leans heavily towards a more Caribbean viewpoint

and interpretation of events. African participants comprised 24 per cent of the total number of interviewees and differences became more pronounced in certain discussions, especially around causative factors of mental health distress and managing mental health difficulties within a church setting.

Occupation

With almost two-thirds of respondents in the two top levels of the Standard Occupation Classification (Office of National Statistics), generally, participants were high-functioning professional individuals (managers, health, teaching, science, IT, engineers). As with many types of research, it could be said that the study attracted a particular type of person from the black Christian population, who tended to be a well-educated, articulate professional and therefore this study is not representative of the wider black Christian population. Twenty-five per cent of participants' occupations were classified as elementary (manual and unskilled work) and 17 per cent 'other', which included singers and the retired. A small percentage of participants were unemployed, particularly among those who were recovering from mental illness.

Previous or Current Mental Health Problems

Over a quarter of total responses were in the form of stories; fifty-five personal accounts were used to illustrate points and experience. This form of sharing was natural, informative and often very powerful; the stories will be discussed in chapter six.

A small percentage of men and less than half the female participants disclosed that they had experienced mental health difficulties. Less than half the females and just

over half the male participants declined to answer. This may reflect the need to avoid being judged, or individuals may not have even been aware they had a mental health issue, illustrated below:

Wendy: I've had six children so in my life I probably went through postnatal but because my life is so busy it passed over me and I didn't know [I had it]. Because I've always had to work full time and look after my house...

Some participants spoke candidly about their mental health difficulties during the interviews. The following extract is a group exchange in response to question 1: 'How do you support yourself during times of distress?' It is a fairly long excerpt, significant because of how it captures participants' lived experience:

Lena: I cry, I cry a lot when I feel distress, and I think a lot. I think about dying. Since my breakdown I think about that a lot.

Researcher: ...do you talk to anybody when you feel like that?

Lena: No, I don't. I talk to XX ... she don't work here, we talk on the phone. Sometimes I get down; I'm always sad, I don't know why. Since my breakdown, several years now.

Kelly: I think I get a bit angry. Sometimes my body shake(s) and everything

and I feel a bit upset and angry. Sometimes I shout.

Researcher: How does that go away?

Orphelia: Sometimes I pray and everything or I read a psalm or
whatever and then I feel better.

Jamie: My appetite isn't balanced. When I do eat I'm not feeling
the effects that I know I should.

Researcher: Are there times when you don't eat for long periods?

Jamie: Sometimes, because I'm cooking for myself I'm not motivated.
Sometimes I just can't eat, but I want to eat. I know I shouldn't but it
happens.

Mark: He's right about the food. Sometimes when I'm getting confused,
I don't know whether I'm hungry or not. Now I don't know whether
I'm hungry or not. When I'm really, really hungry that's when I eat,
normally 4pm is when I come here and get my dinner. Now I
don't want it. So I say to myself when I'm really, really hungry
that's when I...

Researcher: Does anything else happen to you when you feel distressed?

Mark: Yeh I have mood swings but I sometimes....But I like music,
go out walking just to do something to sort of help me.
I've got somebody who helps me, I've got a carer, so you
know what I mean.

Researcher: So that makes a difference?

Mark: Yes plus medication helps as well. I would say it's not too bad now.
Well before I never had no ,... a lot of support before, and you used
hear voices and all that, I still do but at least now it's controlled. So,
but before I didn't think anyone could help me, so when I went to the
doctors, I told him, he tried to help me because I didn't know. The
thing about these things you keep it to yourself, you don't tell anybody
because you feel embarrassed, but um it was much worse, when I
first, about four years ago.

Jamie: I was a hundred times worse because people would be like watching
me, stop their car and watch me because I'd be trying to come to the
X [name of centre]. But I didn't know what to do, so I'd be walking
back and forth you know, I'd be like [gets up and demonstrates].
People stop to watch me and I'd be back and forth and you know, this

is when [name of centre] used to be in X you know; it's better now.

And X support me now because I came here in the year 2000 to X and they support me.

Kelly: Me turn on my music, turn it up, disturb the neighbours,
sometimes I dance to it, it depends...

Some participants became more vocal about mental health issues following their personal experiences. Below a carer shares her experience:

Donna: Even dementia, people don't speak about dementia, but you know some people, like our old pastor, he was a dementia person. My dad's got dementia uum, so it is something that ...

Christine: You never talk about those things.

Donna: I would openly talk about dementia now to anybody, Alzheimer's and dementia because my dad had them both. He had a stroke and then dementia and then only God knows. Not a nice ...

Christine: No. Mine had it as well. My aim is to write a book about it so ...

Donna: Honestly, unless you've dealt with it first-hand, you would never know, you would never know. Yeh, but no.

Other reflections on lived experience will be shared in a later section. We will now explore the key themes which emerged from the data.

5.3. Overarching Themes and Cluster Themes

As part of the refinement process a hierarchy of themes emerged from the data, consisting of themes and sub-themes (Braun and Clarke 2006). Three overarching themes were developed from the dataset: culture, appropriate help and support and Black Majority Churches. A further fifteen main themes were identified: black culture; health and well-being; positive and negative impact of church; positive and negative impact on faith; self-care, factors affecting choice; counselling and psychotherapy; partnership working; church identity; leadership; spiritualising problems; what support churches provide; church role in maintaining mental health; faith's role in maintaining mental health and (being) let down.

To avoid the reader (and researcher) becoming overwhelmed by the volume of themes, and to aid in presenting findings and discussion points, the main themes were organised into clusters under each overarching theme. Each main theme stands alone and is significant in its own right but is linked to other themes.

Essentially, the themes join together to create a web of concepts and participant experiences, which will facilitate a deeper understanding of BMCs and how they impact upon the mental health of members.

The overarching themes and cluster themes will now be defined with extracts from the focus groups to illustrate points and ideas.

Overarching Themes (3)

1.Culture

2. Appropriate Help & Support

3. BMCs

Main Themes (15)

1.Black Issues

6. Self Care

10. Church Identity

7.Factors affecting choice

11. Leadership

2.Health & Wellbeing

12. Spiritualising problems

3.Positive & negative impact

8.Counselling & psychotherapy

13.What support

of church

churches provide?

4.Positive & negative impact

9.Partnership working

14. Church role in

of faith

maintaining mental health

5. Faith's role maintaining mental health

15. Let down

Table 2. Illustration of Overarching Themes and Main Themes

5.3.1 1. Culture (Overarching theme)

Culture refers to the attitudes, beliefs and practices embedded within African and African-Caribbean communities in the UK. The terms 'black community' or 'black culture' are often used interchangeably and encompass both African and African-Caribbean culture, although as previously established there are notable differences within and between the two cultures, ranging from food and languages to the importance of family values and religious beliefs and practices. Some participants relayed experiences based on the cultural context from which they originated and others used black/ black culture to encompass both African and Caribbean cultures.

References to culture were made across the dataset, and below are excerpts which emphasise particular dimensions of black culture which include: black history, the black community and health issues specifically related to black people. This first example is a conversation between two females regarding the lack of cohesion within the Caribbean community, and possible underlying causative factors to the development of mental health difficulties:

Vanessa: ... it stems right back to slavery and I think ... that because I've been watching this programme only recently this week, about the unforgotten slave masters and you'd be very, very surprised. Half of the things that we see on TV, it's a lot worse ... and how they got to Jamaica and what happened, they (slaves) were subservient ... if they showed any aggression, disobedience was termed as being aggressive as well ... they're not being subservient ... We're still seeing ourselves as the underclass.

Susan: But we don't work together do we? If we work together and stood up and said OK, like some of them have done, they wouldn't have a leg to stand on.

Vanessa: We don't trust one another.

Keeping family matters within the family and again lack of trust is the subject of this next exchange:

Hannah: I was brought up, umm the culture, but culture would impact my choices a great lot ... my family culture. My mum always used to say umm, don't tell anybody [laughter] your personal business ... so then the first port of call is I'm going through a problem, it would be, I would head to my family.

Gideon: ... yes I think that [there's] distrust, especially in the black community. I think one of the things about distrust because of how we were brought up ... but my family say, if you tell anybody else they will cuss you about it ... and so people kinda don't want to. I know my, my problems, I don't want anybody else to remind me about it or ... or tell my family ... I think that's why you find that people say well actually, I'd rather keep it away, this is not what defines my family, you know, so , I think that's one of the problems in that we don't want to be labelled.

The following passages highlight two particular problems within African and African-Caribbean cultures, which invariably affect the mental health of present and future generations; negative behaviour is perpetuated within the culture:

Brenda: ... a lot of black people have grown up being told and taught ... there's this thing, you are seen as weak if you can't handle the bad things that happen in life, so you are less likely then, to show anyone that you're vulnerable.

Belinda: ... boy is 14 ... and he was talking about ... they're were getting beaten [physical punishment], and they were talking about getting beating with broomstick and this, that and that and I thought what! You're, it's still happening, it's still happening! ... So OK so that brutalisation is still happening OK. I think that what happens is that we, that level, the tenderness is not necessarily part of African-Caribbean culture, maybe not even part of the African culture as well.

... if you're not kind to yourself if you're not tender and kind to yourself and softly spoke to your children and softly spoken to yourself, and listen to yourself when you're sad, I didn't know what the word sad was until I was about 40, I knew angry [laughter] but in terms of saying sad, I feel sad ... the 'strong black woman' and all of that stuff, it didn't allow for the tenderness and the care, and I think it plays itself out in church, it's not that we don't have the capacity ... it's the culture is such that we don't allow ourselves, and we're still struggling against racism, and you've got lots of black women ... struggling as single

mothers, and therefore everything tells you, toughen up, toughen up otherwise, ship up or ship out.

The importance culture places on family is briefly illustrated here:

Brenda: ... I think when we were growing up right ... we could go to an aunt or ... our gran you know, and sit down and talk to them because you knew that, you knew they'd be able to say, 'Don't worry come on, tell me what's going on,' and there you'll be able to, to share what's really going on with you.

This participant raises the issue of racial and gender differences:

Christine: We're more in the mental home than anyone else, especially the black community yeh. So, what's different about the white folks then? ... Could be because we tend to bottle stuff up, yeh? It could be they're more expressive, they'll find a GP. And black men on the whole, sorry to say ... don't do counselling ... my ex said, 'No, I don't need it.' He actually walked out the counselling.

This respondent felt the community lacked awareness and understanding of therapeutic services:

Frank: When it comes to counselling, psychotherapy and so forth, psychological interventions in the black community, that was foreign as, so it's still not well publicised.

Ethan: Umm, some churches are trying to do more in the community to raise their exposure to do community things, to show that they are trying to relate to them ... there are professional individuals in the church ... so effectively we've got a consortium of business there, so you know, we should be able to give support to everyone that comes whether saved or unsaved (that is, Christian or non-Christian).

The components of culture are broad and complex and become even more challenging when using the term 'black'; two different cultures are addressed as though they are identical and this has become the 'norm'. To disentangle the term 'black' and African and African-Caribbean cultures are beyond the scope and resources of this project; nonetheless, it remains a significant issue to keep in mind as we progress through the project.

Culture permeates both church and community and, in both contexts, mental health is still misunderstood. Central to culture is identity which incorporates: education, confidence, self-esteem, financial status and so on. Self-perception determines how much or how little a person invests in themselves. This investment includes taking ownership of one's health and well-being and being informed about health conditions pervasive within the black community. With this in mind we will now look at themes associated with culture.

5.3.1.1 Themes Associated with Culture

The main themes clustered with culture are: health and well-being, the positive and negative impacts of church and the positive and negative impacts of faith.

5.3.1.2 Health and Well-being

Health and well-being were discussed widely across the dataset. Participants shared very personal accounts, a few are mentioned below:

Gina: My son needed ... that help from primary school and I ended up getting that help when my son finally got into secondary school. At the end when we managed to get that help umm, I found it was like a tick box project and when he reached sixteen, it was as though they wanted to cross him off and put pills into him that I had to fight and say no because they didn't help him, they didn't do anything towards helping him be, nothing ...

Everett Before I was born again over seven years ago, umm I have friends that I associated with that used to be level-headed, though I would say it must be a chemical imbalance and the use of drugs ... it affected them. Umm my Godson, his father who used to work umm in the city before he went to the States and then he came back, he developed mental health issues and then he died. My Godson, his son, up until the age of twelve was level headed but not sure what it was, he went to Jamaica with his grandmother, came back, he's now twenty-two and he suffers with mental health issues ... he got sectioned three times ... and then there's, a friend ... and his brother ... he somehow had mental health issues, turned to heroin and crack ... his sister was also sectioned.

This participant spoke about addressing psychological problems in new converts:

Wendy: ... things happen to you as a child and sometimes it makes you

not even like yourself ... So, until that thing is sorted out ... the person cannot go forward. And it's the same now when you come into church ... a Christian, you get baptised ... get the Holy Spirit and they think that you're going to be healed at the same time. But the problem is still there so eventually that problem is still pushing to get out and if you don't have someone to help you to deal with the inner issue, you can't get the fullness of being a Christian and how the Christian life should be.

According to this interviewee, the church should be leading on health issues within the black community:

Belinda: ... We should be up there in excellence, up there in terms of, we've got the unction of the Holy Spirit, come on now, this is ridiculous! We should be leading ... telling the psychologist, agencies, oh look come on sit down let me tell you ... to my mind, we should be the world-spring of well-being, to be able to articulate well-being ... So now what we have is people having to research and say by the way did you know if you pray certain parts of your brain lights up ... and do you know the research says ... people that pray have greater mental health and they're less stressed. Well we know that! The world is trying to tell us what we know already, it should be the other way around.

5.3.1.3 The Positive and Negative Impact of the Church

This theme recognises the deep and complex link between church and the community. It is difficult to separate the black community and the BMC, because the

BMC originates from within the community and it is the community which constitutes the church. Suffice to say experiences in Caribbean or African communities are often reflected in faith communities and vice versa, demonstrated below:

Hannah: I was just thinking while you were talking, I think that maybe in our black community mental health is taboo, so even if for instance I use myself, I realise because at the initial phase you would be able to assess that this is not how I used to react, something is wrong with me, and it's probably because of pride, sometimes it takes a while to say ... do I go for counselling? Where do I go? And you might say 'Oh shall I go to this person?'... they probably might go and say to somebody else and everyone knows ... Once we educate people and say ... look this can happen to anyone ... it's better for you to know that there's help available ... so again it's to educate the church or the black community ...

Anne: I think what can turn people doolally in the church also, is that they're hearing these messages in the pulpit of goodness ... love ... trust and care ... but it doesn't replicate in their own lives, they're not seeing that they're getting that support from church or from whoever. So sometimes I think that's detrimental to their mental health...

Anita: ... community is a bit more complicated ... all the issues you talked about in the church are in the world (wider society) in general, so that's gonna be a mixed bag.

The church is part of the community and many churches believe they have a responsibility to serve the community. How well church engages with the wider community will determine how the church is perceived and respected within that community. Often, churches offer a range of outreach or community programmes run by church volunteers.

Susan gives examples of 'food banks ... it (church) does help people in the community. We used to put on little school activities in the school holidays.' Homelessness programmes, hospital and prison visits are other common church initiatives.

This theme also relates to how church attendance affects well-being. Susan describes some of the benefits of a church community here:

You know the fact we were in X (name of church) ... and we met, we knew everybody, from all ... parts of the country ... actually were strangers and coming together on a regular basis, we ... made some very good friends ... And it's through church, not through, not through basketball or dance or all of that. We've done music, we've done singing, we play games, go on trips ... because of the community ... Also, I think it is really positive because we come together on a kind of the same level. We have the same thought processes and you know we come together to do one thing and that's to praise God.

5.3.1.4 The Positive and Negative Impact of Faith

This main theme centres around how faith impacts upon mental health and well-being. Faith is personal and powerful; it governs all areas of life including decisions

around health, values and attitudes, some of which are considered outdated by wider society. Some participants' views are expressed below:

Anita: Having a faith I don't feel is negative for me because ... in having a faith, personally it's been nothing but positive.

Freda: Yes, for me ... having a faith is positive. Having a faith in the community, it can be ... positive ... if that community's healthy ... people who are mature and healthy ...

Frank: So in terms of faith ... [it] is my belief system in the eternal God to know that He can do all the impossible things that, although you go to therapy and the therapist is able to help you to understand, to explore, to probe and to bring to the surface stuff that was hidden, but there's certain things that he or she can't move. You realise that there are deeper levels, you would call it the unconscious mind, which is the spirit, or the subconscious, as Freud talks about the subconscious and unconscious, but it's spirit, that's what He's talking about yeh you realise that the therapist can't get there yeh so therefore that's where the faith comes in, because you've decided this is a situation beyond my comprehension, the therapist's comprehension and their ability to bring healing in that area, that's when you tap into the faith, that's when I tap into my faith.

Hetty suggests faith can have a negative impact when there is 'gossiping, competing, class issues and a village mentality' (relates primarily to African culture).

Here Cara shares how faith can affect her in a negative way:

I call it the 'Jonah effect', where God wants you to do something that you really don't want to do or actually your natural response is to do this and you know the right response is to do that, that inner kinda of weathering and wrestling ... my faith versus just me and my desires ...

5.3.2 2. Appropriate Help and Support (Overarching Theme)

The second overarching theme relates to the range of resources and therapeutic interventions provided by BMCs and outside agencies available to black Christians. 'Appropriate' refers to suitable, accessible and culturally-sensitive support. Participants provided examples of what they considered adequate and inadequate interventions:

Rebecca: ... I feel some people [counsellors] are just a text-book version and if it's text-book version ... I don't wanna be, you know, just a sample, I'm a person, I really want you to talk to me as a person sitting not, not a text-book sample ... If a counsellor comes recommended, word by mouth then yeh, that person, I might consider it. If it's someone I might, if it's somebody I'm gonna have to go through the phone book and find, I thinks I'll ...

... Mental illness is a big, it's a huge umbrella, OK, so I've got depression, big deal. There's someone to help me, I'm not totally

insane, I don't have to crawl under a rock somewhere. So, I do believe it's letting people know that there are different strands, meditation or therapy or counselling or whatever it is that's out there. Be aware that they're out there. It's awareness.

Belinda: ... I wouldn't be speaking to an external counsellor, I wouldn't speak to a secular counsellor. No, in the past you know before I was saved, I went to Relate and I spoke to the person ... But I always step back from that I don't want the secular world's understanding of healing because I think it's very limited. Umm, at the same time I do feel that the churches' model by and large is also very limited ...

Researcher: What is the church model would you say?

Belinda: ... the church's model either ends up being the secular model at one end of the continuum or the other end of the continuum its everything is demonic ... [should] combine the spiritual understanding with the kind of psychological underpinning but the spiritual drives the psychological not the other way around. Umm, I really think that the church has taken on the secular understanding of mental health – good mental health – and I would really like to see more of initiatives like EIIIEI Ministries and their training factored into churches training and the general understanding.

Here, participants give accounts of encounters with statutory/external services:

Frank: I had no knowledge of anything or anyone called therapists, I know psychiatrists, but I know of no counsellors, I didn't know such things existed and umm, I remember meeting with, umm, a couple psychiatrists, I was interested in meeting with them actually, because I thought they have the answers to my, my situation, umm, and naively, of course, they themselves weren't even keen on listening, they were very, umm, they were sort of like um, they were seeing this black person as a, a, a little, what's the word I'm looking for? Somebody to experiment on, yeh, more than help yeh, so that in itself threw me into chaos.

Collette: A situation at work ... I was offered free of charge, umm six sessions so I did make use of it. So, I don't think it has to be either, I think the two can work hand in hand. I think there's also ... the stigma that's attached to counselling within the church, umm, so at times other people will go without it or they'll find somewhere outside of... the church to access that counselling. Umm, and I also think it's almost seen as ... this lack of faith that if you, if you're going outside, and this is really part of the reason why people don't access it within the church ... if you can't handle it then you're not strong ... you should be able to pray about it and God should be your only, your sole counsellor.

Ethical concerns such as boundaries and confidentiality with regard to church-based counselling are raised by this participant:

Tina: I think its recognising that there is the need, making it confidential, safe, have a safe environment where people can come and say this is the concerns ... because there are people in the church that approach me to counsel them and I said 'I can't because of our relationship' but then I don't know nobody else to even signpost them to, so I've had to take them externally and they wanted a Christian therapist.

Spiritual intervention was considered appropriate support by some individuals but with mixed results:

Abigail: ... if you're fortunate, there are churches with amazing prayer, prayer teams and prayer times, and there are churches who counsel ... they may not offer deep professional counselling, but there are a lot of churches that have older women, that's even less and less now ... when you go to prayer, the intimate prayer ... often intimate prayer groups can really help a lot. Umm and also ... teaching people how to, how to access God via praise and worship etc ...

Wendy: Years ago, I've been in church a couple of years, children were growing up and something happened to one of my daughters and you know, I went to speak to one of the mothers ... I haven't got any trust in that ... so since then I take care of it ... That's why don't tell me that you didn't go and train to be a counsellor and come and tell me that you're going to counsel me because you can't. You can tell me about God, you can encourage me with it, but if you don't know how to do

the thing the right way, sometimes you make a situation worse than it already is ...

For some participants practical support was deemed the most valuable form of help:

Isadora: Well, I have my family back home to help me before I came here ... since I've been here I was working in a hospital cleaning and so forth, but I get in problem because when I was working at the hospital, they said I get too much money ... but when I get in that trouble I didn't know what to do, sending letters, letters, letters every minute. I did have [name of centre] and I did come here and X helped me, and stand up for me, so it was OK.

5.3.2.1 Themes Clustered with Appropriate Help and Support

The main themes clustered with appropriate help and support are: self-care, factors affecting choice, counselling and psychotherapy and partnership working. We will begin with counselling and psychotherapy.

5.3.2.2 Counselling and Psychotherapy

Surprisingly, this main theme was discussed widely across the dataset. It became apparent that for some interviewees, professional counselling was a vital and missing resource in the church. Participants shared a range of experiences, for example:

Debra: I've gone to, umm, therapy on and off for a very long time [laughs], umm, but at first I didn't know what it was, it's not something that's in

our community, that you're told go counselling, in fact I was actually told if I went there I'd be in trouble [laughs] and it was something that was provided for me by my school, at the time, because of what was going on in the family and support for myself obviously. But my dad told me whatever happens in the family, stays in the family, you keep it there.

For some participants, faith replaced the need for therapeutic input and even the need to take medication, as seen in the following excerpts:

Oprah: Yes, I was even seeing a counsellor but it didn't help at all. Umm they suggested I go to a psychotherapist ... and even there was the tablets, two tablets they gave me to reduce the depression because it was going higher and higher. So, my doctor actually came, my daughter is here now, she came and she forced me, 'Mummy you must take the tablets.' When I remember Jesus, I say 'no I'm not going to take the tablet,' and I didn't, I didn't, I continued with my 'thank you Jesus'.

Lucy: ... There were times when I need to pick the phone up and have to speak, but I've found since ... being in the Catholic faith, they're just so many other avenues you know, going to Mass, receiving Holy Communion on a daily basis ... the blessed sacrament, these are things in place now ... in former days I would have either been seeing someone you know ... problems at work you know, going to have

Cognitive therapy and things like that. Whereas now I've found the answer to everything is through my prayer life.

Francesca: In my church there are qualified counsellors which the senior pastor would refer individuals to. In the first instance individuals may speak to one of the leaders (deacon, elder, minister or one of the pastoral team). If that person thinks the person requires further assistance then they are referred to a counsellor, generally counselling referrals are made by the senior pastor.

Yasmin: People are now going through counselling because the more you speak about it, the more people think it's OK and being Christian and depressed is actually ... it doesn't make you less of a Christian.

Susan: I've not actually been to a counsellor, but I would have to research and read about the counsellor

Participants discussed the differences between pastoral counselling and professional counselling, here are some thoughts which emerged from the discussion:

Researcher: Do you think they're the same?

Vanessa: I think they should be the same.

Anne: If it's pastoral then they should have that same level of professionalism ...the church will have the spiritual guidance ... but on top of that the qualifications, the professionalism, the persona, the ability, do you know what I mean?

Researcher: Are you saying they should be the same in quality?

Anne: Given the ... number of black people in mental health [institutions], the amount of black people with [poor] mental health in churches, you can't just have a pastoral team, you have to have the [professionals] ... because of the statistics you need that level of professionalism, qualification to deal with that level of, do you know what I mean? The statistics that's out there.

The need for trained, qualified professionals is an associated theme which is discussed further on.

5.3.2.3 Partnership Working

This theme is closely associated with counselling and psychotherapy, participants explained why it was so important:

Yasmin: Why does it have to be such a big spiritual hoo haa? Why can't it be so normal that 'listen ... I can't really help you here, but I can signpost you? I wish there was a working relationship, like you know, say in every borough, say in X here that the church was connected to ... and

not just for my sake, but for people who ... it's not comfortable for you to talk to the people who you sit next to in a service. It's like a problem. They might be the problem [everyone laughs] it's not comfortable.

Vanessa: For X [name of daughter], I had, and everybody should have a support package, [and] individuals like a support worker ... they just come together to make sure

Anne: Even if people in church are diagnosed with schizophrenia or whatever, yes they should have the support from the church who should be, supposed to be working with professionals in the community, to feed into, feed into... as part of their care and their recovery. I think it's important especially the Apostolic church to kinda collaborate with the community. The services are in the community, even if they can't provide it in the church themselves, they need to go out and source out those different organisations, whether you bring in organisations, they should do talks or whatever. I think they need to do more, because the Church of England does that ... has a say in parliament, they talk to ministers, all of that thing. Do you see where I'm going? Apostolic churches ... once they get their own house in order, to factor in and collaborate with the community, and other outside agencies.

Belinda: ... but it's all about the intervening facilities that's needed, not just around mental health or physical health but a whole range of things around well-being. It's like you know the pastors need to be and

leadership needs to be retrained, so that it automatically will say yes I want Healthwatch department, I want police department [clicking fingers], I want this department come down here and whatever to come and speak to us , or I want to find out what they have to offer and think about the best way to package it back to our members.

Gideon: Not many of us in church actually refer on. As far as we're concerned 'I got it' and take for instance we've got a lot of pastors, and I respect pastors, but a lot of pastors are not trained in counselling no way at all, but they will go be marriage counsellors, they will go and be mentors and they mess things up ...

Gary: Church needs to go into the mental health system.

In this passage Alison illustrates partnership in action:

Alison: I'm on the governing board of X, I'm aware of some of the health issues, so the diabetes, the heart conditions all of that ... so ... we bring people in from outside as well as we take people from the church to actually go and see what's going on ... So part of keeping well is about the relationships they have in X church but it's also about keeping well outside of the church and recognising that your walk with God isn't just your physical church it's about who you are in the community.

5.3.2.4 Self-care

This main theme connects with most of the other themes. It relates to the proactive measures individuals take to ensure they remain in good mental health, but also the mechanisms used to manage when mental health distress occurs. Respondents gave many examples of how they looked after themselves, some of which are mentioned below:

Cara: ... I tend to write my prayers cos I just find I can get it out better, umm sometimes I will speak to people, very close circle of friends who I know understand me; umm, other than that I do tend to try to kina work things out myself ...

Elsa: I sing ... I just sing if there's something bothering me ... Because when you're singing you're sort of working it out in your head, you know, it's as if singing just brings on a calm or a peace.

Anita: ... Umm gospel music umm I'll just immerse myself in gospel because I've been in church so long there are certain artists like Hawkins, Andre Crouch, people like that, umm, that are literally singing the prayers that I'm writing, they put it to melody, you know.

Peter: I read the Bible ...I read whatever scripture, I read it and then I go through it I get the strength, God strengthens me, I find that helps. I also have my rosary in addition to that.

- Matilda: ... I go to confession, this is something that the Padre, I go to Father X and he helps me, because it's someone I really feel can help me, he does help.
- Sherry: ... I would analyse the situation that I'm actually going through and try and understand what it is that I've just gone through and try to understand why I've gone through it because, being a Christian, I know that through life, God works everything out ... what is God trying to show me? What am I supposed to be learning from that situation?
- Vince I won't go to God unless it's really, really necessary. It would have to be something really dark because I think there's someone worse off than me that needs Him. So, the way I sort of look at sorting out my issues is either speak to my wife or my daughters ... You must talk, if you bottle it up it will just eat you up ... and then you just start talking to yourself and doing stupidity.
- Xavier: Before coming to God I used to be into drugs ... so once your mind's altered and that, you're not really ... your thinking is not normal. And now, I can't really say I get depressed and that's quite a strong statement to make, but ... when you're coming from where I'm coming from, everything now seems perfect. Even though it isn't ... but I never make it hold me down for too long.

Other self-care approaches mentioned by participants include: talk to and trust God, walking or sitting in the park, meditating, singing and dancing to gospel music, friends, positive reinforcement techniques, learning from the past, worship, being hopeful, faith in God and gardening.

5.3.2.5 Factors Affecting Choice

This is a main theme which encompasses influences on decision-making when seeking help. Put simply, why do people choose to do what they do in times of distress? This theme is also connected to other main themes such as self-care, culture and others, to be discussed later. Participants spoke extensively on this subject and also highlighted the qualities and skills they felt a helper should possess. A few passages are mentioned here:

Debra: When I decided to go back to therapy, I went online, I'll kind of look at age as well ... If you're a lot much older then you're gonna judge me because of where I've come from, so I was way outside of my local area, not black and I didn't really care if it was male or female just as long as it wasn't black...

Freda: ... trustworthiness, honesty, you wouldn't judge me. If I said to you that last night I was wherever, you know, and judge me by what I said, it depends on what it is.

Kelly: Sensibility, pride, interest

Lena: To acknowledge that you're there.

Researcher: To stop ignoring you?

Mark: Yeh, yeh just be kind and gentle that's all you have to be ... good manners, just say hello and all this ... it does not take much to say ... [hi] ... but some people they think it's too hard you know, it's just they don't bother.

The race and gender of the helper were not discussed in any great detail across the dataset but Wanda shares her views:

Wanda: ... Colour doesn't matter to me. I went to see somebody I didn't know ... because I'm not a talker, I've never been, I keep things in the family. So, when I saw a therapist it was somebody fresh, somebody new ... my life was in her hands as far as I was concerned, because trust was the first thing ... I trusted this lady because now I was, I was gonna open my life, so it was all about confidentiality, but I felt safe ... I thought that ... I would never ever need [therapy] ... I got my family, I got the Lord, I got prayer, but for the first time in my life, and I'm now in my 40s, I've seen a therapist and it was the most empowering thing I could have done.

5.3.3 3. Black Majority Churches (Overarching Theme)

Participants focused on many aspects of the BMC. Interviewees share their expectations of the church in these excerpts:

Alison: ... We have a role inside the community, yes, and what it is is, we will go in with ... our rule book ... but well-being and a whole range of other things ... counselling is inside the Bible, relationships is inside the Bible, dealing with people's practical issues, so if we're talking about wholeness, if you're only gonna give someone the mental bit but not the practical bit at the end of the day, we know that if you look at the wider term 'mental health' you know that if people don't have the housing, the education the food, the whatever it is at the end of the day, no amount of church on its own is going to deliver it and so church still needs to recognise that it is still part of its role at the end of the day; I mean, I can go on and on.

Zechariah: ... and I just find that, we all go through that pretence that we have to say things ... to suit those, even to the point where, I'm on my own, but in front of everyone I'm OK.

Belinda: I think the church has a great role to play ... in terms of building that resilience, there's a place that people go to on a regular basis ... so in terms of isolation, which is a big killer in terms of mental ill-health ... I think we haven't really promoted that sufficiently in the way that we should do and I think that that is one of the great umm assets that churches have.

Priscilla: Unfortunately, because of the lack of knowledge – and I’m not beating up our forefathers ... they did as much as they could with what they knew. Some people say ‘Oh they [criticise] ...’ no, no, no, no, no. I’m not doing that; I’m thankful to where they took us. But thanks be to God, we’ve gone a bit further now, and I hope people coming behind us will go even further.

5.3.3.1 Themes Clustered with Black Majority Churches

The cluster themes associated with this overarching theme are: church identity; leadership; spiritualising problems; what support does the church provide?; the role of the church in maintaining mental health; the role of faith in maintaining mental health and (being) let down. They are individually examined in the following section:

5.3.3.2 Church Identity

This theme is important for several reasons; how a church defines itself will determine its sense of responsibility, not only to the congregation but the wider community. One participant put it very simply:

Alison: Somebody said the church is a hospital.

One interviewee described church as ‘an organisation’ while another mentions ‘Unfortunately some Pentecostal churches are set up as a business OK, they run themselves as a business.’ Discussion points related to this theme included: the style of leadership, the size of the church and whether the church was inward- or outward-

looking that is, whether there was greater emphasis placed on delivering in-house activities and events or evangelism and external outreach programmes.

5.3.3.3 Leadership

This theme refers to a range of factors concerning pastors or leadership teams. The leader is a central and powerful figure within the church. They are hugely influential because of their standing with God (sent from or called by God). Participants comment on the attitude towards leaders and accessibility, in the passages which follow:

Alison: ... my take is that we need to kind of move away from seeing ... yes the respect according to the person at the top, but I think when you pay deference too much to the person at the top, you don't build relationships ...

Lucy: My first present here was with Father X ... I think he just came and I started coming here...he identified the pain, there was just something about the way he, the reflection and meditation ... just brought them home to you.

Gina: I've only been here a year now and the pastor of this church he has offered to meet up and talk ... I have been to a pastor before with something that I was going through ... if I hadn't had been to him that point would never had happened and that really helped me to find out who you are, you know. Because sometimes it takes somebody else to tell you something.

Anita: I do talk to my pastor a lot but he's a very busy man ... a lot of people bring their issues to me, so then I go bring it to him with their permission, and we do have that relationship and I know how busy he is ...

This particular speaker had a different perspective and highlighted personal difficulties some leaders face:

Gideon: ... if I'm a pastor and I'm going home and my wife and home situation is affecting me, the last thing I want to know even though I'm showing you a nice face, is to hear your troubles. So I'm gonna tell you, quickly brush you off, pray. If things don't work out, guess what's my next answer? You didn't pray enough, simple, so what does an individual do in this circumstance other than pray, pray, pray?

How equipped leaders were at addressing mental health issues was a major topic of discussion across the dataset, this participant shared her story:

Debra: You know the first time I went to see, umm, a pastor and I was just new you know, starting off and my friend said go and speak to one of the head pastors, I was a bit hesitant and you know I told him what was going on with me and what he said to me was, you're not physically damaged so thank God for that. And I thought, What? actually, I would have been better off physically damaged than psychologically damaged because the psychological effects have held me down for so many years. I'm in bondage and your words are not

making it any easier ... what I wanted him to say [was] 'OK you know I'm here, talk about it.' I've never mentioned it again, you know so that's why I decided to go have my therapist outside, but also have my relationship with God that I'm building on and I just kind of know what to say, and what not to say in church.

Freda: I was listening to a pastor ... because he was saying that unless you know the proper diagnosis, the person will not experience the healing ... you need to find out what is ... causing whatever may be the breakdown ... because that's when you can properly deal with it ...

5.3.3.4 Spiritualising Problems

This theme involves attributing psychological/mental problems to demonic or evil spirits or as a consequence of wrongdoing (committing a sin). Alison clarifies this further:

Alison: ... recognise what is reasonable to expect within the walls of the church and then ... how you can find help and support outside. Sometimes it's about the church knowing enough ... not over-spiritualising things; we know there's a spiritual dimension to everything, but I think sometimes we're over-spiritualising things in a way that the practical dimension just goes out through the window. And I think there's a responsibility that needs to be had, particularly when you're talking about health and social care issues, because on a very practical basis, umm, people do need help and support.

Other accounts of when problems were spiritualised include:

Barbara: Yeh, like not wanting to acknowledge ... there was something wrong with the person, like it was almost their fault. So, it was something to be prayed against rather than, than helped and supported. It was almost like belittling certain people because they were different, even though you were in a church if you were slightly different they'd almost make a joke of them or wanted to pray out a spirit or a demon or something ... rather than in that supportive nurturing way.

Anita: I can only draw on my experience from obviously with church ... I can identify at least two, three people that had real challenges with mental health issues, and, um, I can't remember any being referred for professional help. Praying and stuff like that, when that failed they were pushed to one side and invisible ... And I think really that being the majority, you know, that's the common outcome really.

Anita goes on to offer an explanation as to why spiritualising problems is commonplace:

I think one of the key challenges from the church, especially when it comes to that, anywhere in the New Testament, epilepsy or other things like that is always ascribed to spiritual, and that's where it became then a taboo. Because if they [leaders] were to ascribe to the doctor's diagnosis or whatever, are they then moving away from their faith? And that's where I think

the challenge is, it's about change. But I think increased knowledge and understanding of that arena, psychiatry, psychotherapy [will help] ...

5.3.3.5 What Support Does Church Provide?

This main theme reflects the practical intervention made by churches when an individual is experiencing mental health distress. It is linked to the theme positive and negative impact of church on mental health, and other themes connected to appropriate forms of help and support. Participants give examples of what their churches offer:

Orphelia: My friend from church X who was there for me when I was unwell, she came to the workplace and told them that X's not well enough and if she's not well enough could they pay out so she could have the benefits, so she doesn't have to, umm, come back to work. So they started the procedure eventually at work and I saw a doctor and my friend came and saw the doctor with me. So they signed me off on medical grounds.

Collette: We do have a counselling service and as a team of counsellors ... each month we go to the different churches, umm, the churches will tell us what the issues are and then we either tailor the programme to whatever the issues are. Sometimes we'll have like a surgery at the end of the service so individuals will come and see us on one to one and then we ... direct them to the counselling service.

Frank: I do this workshop called managing your emotional, mental and spiritual well-being. So, I focus on the mental and the psychological and the emotional before I bring in the spiritual ... and look at the Biblical perspective how you then intertwine the Biblical into the psychological ... so I do a lot of teaching and because my pastors are open to all that, that is very encouraging ... I would love if there was a counselling service in my church and It's not because we don't want to have one it's simply because it's not our own building.

Vince: Well umm we actually speak to the school, speak to the mums and actually been to the school ... it's not just adults that have got an issue, it's the youth ...

5.3.3.6 The Role of the Church in Maintaining Mental Health

This theme relates to the proactive role of the church, focusing on the interventions which help to prevent mental health difficulties. Here participants share their views:

Francesca: Actually, going to a church service can be a very liberating experience ... through praise and worship I am able to forget about anything that is bothering me and ... give thanks for the blessings which have been bestowed upon me. Faith and faith communities or attending church gives us the opportunity to take our thoughts off ourselves and focus on God. When we do this, we have some respite from anything that's happening in our lives which is causing distress.

Hannah: The Bible tells me ... we have to work together ... support each other and ... from that perspective I feel that the church has a responsibility to contribute towards the mental health and well-being of the body of Christ (the church).

Frank: We are body, soul and spirit, not just simply spirit, and so the whole person needs to be addressed, needs to be dealt with.

5.3.3.7 The Role of Faith in Maintaining Mental Health

This theme encapsulates the personal experiences of participants in relation to how faith impacts upon well-being. Participants were very aware of the personal benefits of faith and its multifaceted nature. Consequently, participants described the impact of faith in different ways:

Isabel: Well I feel it gives you that inner peace and no matter what's all around you, you have that assurance and then that carries you, especially having weekly meetings you have that trust.

Nichola: To share with anybody in need, I think is most important ... sharing that's what I've noticed, if you have the mind to help others God will help you ...

Anita: My faith it does keep me mentally strong, and [at] most challenging times, my faith is my bedrock, it's a corner stone.

Rebecca: ... for me, um, it's knowing and having the confidence that I believe that God is my Father ... they talk about clutching at straws, sometimes it's just one straw, that's the only one thing left. But for me I have to clutch at that because, that's what I have, that's all ... ultimately, I believe that He's [God's] going to help me whether He'll put the right person, He might lead me to the right person, the right position or sets me up in a place where I can get support. But ultimately, He's gonna do it, and that's what keeps me going, I think.

Lena: If it wasn't for God I wouldn't be alive now. He saved my life. I would have taken my life.

Jamie: I've always believed in God, I still believe he cares for me. I do believe if I didn't believe in Him I'd be in a worse position.

5.3.3.8 Let Down

This theme focuses on the disappointments experienced by participants and how they were left feeling at the point of seeking help from the church. This too was an area which generated a lot of comments across the dataset.

Orphelia: I was going to Seventh-Day Adventist church for years and what happened is there was this man, he's the usher and I know him and he knows me and when he sees me he don't talk to me at all and I

feel like he might get upset I'm coming there or whatever, I don't know but I just stop going there ... and we used to work together.

Jamie: They [church members/leaders] don't know how to, they wouldn't admit that but I don't think they're aware of how to approach you or deal with it, and it's not a hard issue.

Frank: ... some of the negativities is being judged, being stigmatised, being labelled, being umm, umm, quashed or how you want to put it silenced, not being able to talk about the situation you know, being identified as weak and so therefore it discourages, it demoralises and you feel unappreciated or undervalued as a human being, and because of that it's difficult to share what is really going on. So whatever you share it's like you're, it's like a shadow of what's happening, a façade, you stay on the surface, you're not going deep and because of the way the church might, I use the word might respond, because to bear this in mind it's not every leader that will respond that way, but there are members within the congregation or within the ministerial or pastoral team that will respond that way. Because... a lot of leaders need training in these areas, they can apply and identify what is not just spiritual but these are stuff that is coming up because of various bad, traumatic experiences in our lives.

Cara: ... so I don't know whether anyone else here is from Africa? ... woman [pastor], accused her [mother] of being crazy ... I was in that church from eleven to eighteen and that was one of the most hurtful

experiences that I'd ever gone through, cos I considered these people family, and it was the last time I went to that church. So, once I left home ... I did try to find churches around that area and then I thought, you know what, what's the point? It's going to be more of the same, so I stopped going to church and started worshipping at home, and I've done that for about a year and a half now, and I would actually say I'm more closer to God than I ever was going to church in all honesty.

Frank: The problem ... that I faced was that where do I go with this? Because the church pastors could not handle it they, they, you were stigmatising, they talk about that you have sexual issues problems, sexual problems or you were going through this and through that, and hurt by this person and this person did this to you, you were looked on upon as a, almost like a *persona non grata*, somebody who was rejected and somebody that does not fit in this environment, you shouldn't be here. So it was difficult for me to deal with all that in the church, there was nobody to contain or to hold me emotionally or psychologically, they were just about able to hold me spiritually, just about [laughs]. So then the other side was then just locked off.

5.4. Findings

Two of the eight interviewees had not participated in a focus group but volunteered to be interviewed. Several participants were invited to take part in individual interviews, the individuals available were: Isabel, Vanessa, Zechariah, Frank, Priscilla and Belinda.

5.4.1 Individual Interview Themes

(See Appendix 21: Original Codes/Nodes Individual Interviews)

Using Nvivo one hundred and thirty-four codes were generated from the dataset. These codes were condensed into meaningful categories and finally into key codes to address the research questions. Following immersion into the data, and repeatedly engaging with the transcripts, the codes were further reduced to create seven main themes: 1. Define mental health; 2. The impact of faith and church attendance on health and mental well-being; 3. Why do so many black people attend church in the UK?; 4. Why are so many black people in the mental health system in the UK?; 5. Useful help from the church; 6. How would you cope with a therapist or other service provider who did not acknowledge factors that are important to you such as faith or race?; 7. What was the group interview experience like for you?

5.4.2. Summary of Findings

Producing coherent and manageable themes centred around the research questions, required the careful selection of salient accounts, on the basis they would add further dimension and depth to the already rich and comprehensive focus group data.

The seven themes are non-hierarchical, independent and significant in their own right. Nevertheless, they interweave with each other and also interconnect with focus group themes.

These main themes will now be introduced individually. Extracts from across the dataset will be selected to illustrate points. Contributions that hold the most significance will be incorporated; excerpts supporting or challenging existing literature will be noted and examined in the discussions section.

5.4.3. Main Themes

1. Define Mental Health

This first theme prompts respondents to explain the concept of mental health; a simple but important question. Mental health has received increased media attention in recent years, but less so in relation to black people within the mental health system, unless violence or fatality are involved. Given that black people are over-represented in the mental health system, this level of awareness is very positive. Participants' explanation of mental health was informed and clear. However, this does not appear representative of the knowledgebase within the church and black communities in general.

Priscilla's definition of mental health very much echoes responses of all participants when she describes it as:

A state of well-being which allows an individual to obtain or realise their potential and being resilient enough to cope with life's challenges.

2. The Impact of Faith and Church Attendance on Health and Mental Well-being

This theme has two elements; faith and church attendance (not always synonymous with church membership). Although interrelated respondents in the focus groups made a distinction between the two. Generally, faith was deemed as promoting more positive outcomes than faith communities. Restrictions and interpersonal issues were cited as two of the many reasons why this is the case, although corporate activities such as singing and praying were considered beneficial. This theme also allowed previous interviewees to elaborate further on comments made in the group.

Both Vanessa and Frank expand on ideas shared during focus groups. They add the following:

Vanessa: My faith impacts my health and mental well-being – helps me maintain focus and purpose and direction. Attending church provides inspiration and socialisation where I can build positive relationships with others thus minimising the feeling of complete isolation.

Frank: I have attended churches in the past that makes me feel depressed and discouraged because of their judgmental and controlling attitude. On the other hand, church attendance it helps me to have a place of release from my stresses by way of group prayers, singing, music and dance.

In the next extract a very personal account relating to the positive and negative benefits of faith is shared by Rochelle:

I think that if it wasn't for my faith, I would be dead, but in the same sentence, I feel as though my faith has also had a negative impact on my mental health from a human interaction perspective. When my mental health is bad I sometimes find that my faith is not enough to stop the negative thoughts, and there is no one even in the Christian community that will understand. I have been a member of various churches over the years and at times I would have a panic attack at the thought of going to church the next day. Now I choose for the sake of my mental health and well-being not to attend any church, and instead worship God at home and as a result, I have seen a massive improvement in my mental health.

Liz reiterates views expressed by other participants on the subject of faith:

... Knowing that I can talk to God at any time [pray] about problems that I experience provides reassurance that I am not alone in my situation. It is like talking to a therapist. Going to church enables me to meet with other people who share the same beliefs and I can be a part of a community – providing spiritual and social benefits; I can build trusting relationships with others and we support each other through ups and downs ... Being together in an atmosphere of singing, music and worship gives a great boost and makes you feel good.

3. Why Do So Many Black People Attend Church in the UK?

Growth of BMCs in the UK is the next main theme because spirituality is central to the life of many black people and is considered a part of black culture by many.

Could there be other factors contributing to growth such as socio-economic factors?

Participants provide suggestions:

Frank: ... it is their culture and practices to have faith in God as a way of dealing with issues and situations beyond their control.

Isabel: History ... going through slavery ... when things not going our way we have hope Church ... [is] part of who we are

Liz: I think many black people have often come from backgrounds where possibly their parents, grandparents or other family went to church regularly and believed in God and they have seen the benefits for themselves. I think when a church is lively, has a lot of children and young people attending; provides support and social activities, meets the needs of people and its community it is relevant and people are likely to attend. At the same time I think some black people are becoming more anglicised in their attitude to religion and do not see the need to attend church.

The idea that belief in God and the benefits of Christianity are visible is important.

This suggests the church is a reference point for people and may explain why people turn to church in times of distress. The emphasis on children and young people and offering a range of social activities provides a number of incentives which may appeal to different generations.

4. Why Are So Many Black People in the Mental Health System in the UK?

This theme is significant in that several participants spoke of their own mental health difficulties and/or that of a friend or family member. Given we cannot separate the church and the community, this theme highlights the serious problem within the black community and the church; mental health is not being sufficiently addressed; black people remain ignorant of what mental health is and how to manage it. Participants offer a range of explanations:

Vanessa: People may feel isolated ... as family unit and relations are less bonded

Priscilla: ... the inability to cope with day-to-day challenges and issues, such poverty, marginalisation, immigration, divorce, AIDS and delayed contact with services/cutbacks in services.

Isabel: No job, black male, the way this society treats them ... the system works against them, police works against them ... young men are disillusioned, when it gonna be stopped?

Zechariah: ... us black people hold a lot to ourselves ... seen as weak to show emotions, a cultural pride that slowly kills ...

Rochelle: Because black mental health is hugely misunderstood, the system is governed by white middle-/upper-class people, who have no understanding of black mental health, culture, or faith.

Frank: ... it could be to do with misdiagnoses ... this could be to do with stereotyping. It could also be ... lack of extended family support when a black person experiences trauma and losses in their lives, which causes conflicts and confusion in their minds.

Liz: The mind is a complex thing ... we don't really fully understand how to help people with mental health problems in a holistic manner. In addition to systemic racism ... cultural differences ... are also issues. There are insufficient black consultants, policymakers, and books on mental health from a black perspective to increase awareness and bring about change ... there is inadequate access to counselling and more holistic services and an over-emphasis on medication ...

5. Useful Help from the Church

This theme is concerned with the responsibility of the church in looking after its congregation and is an extension of the research question used in the focus groups. Its importance centres around expectations; what are reasonable and realistic expectations with regard to what the church offers its members who are experiencing emotional distress? Participants were invited to share their thoughts:

Zechariah: I would say group sessions ... people work best in a group, collective encouragement, collective experiences.

Vanessa: Counselling, practical support, information and signposting. Relevant scriptural direction, inspiration and biblical encouragement in relation to my feeling and experiences.

Participants also mentioned other useful interventions and support mechanisms, such as advocacy, befriending and signposting. This also ties in with partnership working explored earlier.

6. How Would You Cope with a Therapist or Other Service Providers Who Did Not Acknowledge Factors that are Important to You Such as Faith or Race?

Training and service provision are central to this theme. Practices and attitudes are going unchallenged and unchanged within training institutions. Increased awareness and respect for cultural, racial and religious factors is needed.

There was a clear gender split in responses to this question. Male participants were unfazed about practitioners/professionals who did not respect race or religion and evaluated possible positive outcomes working with someone like this, whereas the females were less tolerant:

Frank: It's good to hear other professionals' views about a situation as sometimes faith-based therapists and service providers can be blinkered and see a problem from only a spiritual viewpoint. So I have had to deal with this situation in the past and handled it very positively.

Zechariah: I wouldn't be too concerned as in it wouldn't bother me, I have already seen intermediate counselling but the 12 sessions ran out. I am up against the wall and struggling to just deal with the lengthy waiting process. So much as I am already trying to get a therapist and I praying God will connect the right person to me, that is if He thinks whether I need it or not.

Females participants responded in this way:

Isabel: Messes things up.

Vanessa: I would feel undermined and disrespected and I would not feel the liberty to trust them as much.

Rochelle: I have had people like that in the past assigned to me up until recently and the working relationship is very short-lived. I just refuse to work with them point blank, as I feel that they are wasting my time and theirs and making what is an already a bad, stressful situation worse.

Pricilla; It has the potential to be quite challenging, disempowering and distressing if my faith, values and views were neglected.

Liz: They could not really understand my experience and values, and what I find supportive. It is more likely that they would misinterpret what I say and do and make judgements that can adversely affect me. I think this would make me feel more anxious and unsafe.

7. What was the Group Interview Experience Like for You?

This final theme is important in that it provides the participants with an opportunity to reflect, to pause and think about experiences regardless of whether the impact was positive or negative.

Isabel: Felt very enlightening experience. Good to hear where people coming from, things common, very good.

Felt more of an affinity with the group? Very enlightening, opening up saw sisters in a different light, very revealing, felt closer to them. [We] Don't talk enough, tend to do, go back and express feelings. Very positive experience. Faith start looking at faith more. What was important, think on impact on life? Spiritual impact on the personal.

Vanessa: It was very useful to hear the point of views from perspectives. Perhaps it may be useful for the church to have group therapy sessions where participants can share experiences and their ideas of how they manage challenging situations.

Zechariah: The interview was very eye-opening, listening to other perspectives and interpretations, also helped to see there is a great need for talks and work in church to help those suffering as the church is for the needy.

Frank: It was very interesting because I was able to listen and learn from other participants' views and experiences.

Belinda: I've certainly been thinking about the research and it's triggered many a conclusion. I went to an Ellel Ministries over the weekend ... they agreed with me about the legacy of slavery ...

Priscilla: ... it was thought-provoking for me as it made me think about my own well-being and how I can continue to support others to maintain

mental health. It also encouraged me as a pastor, to continue with programmes promoting mental well-being and awareness.

For the purposes of quality control and ensuring participants continued to be involved at key stages throughout the project, participants received a copy of the findings for comments, changes, questions or to withdraw their contribution. There were no amendments or withdrawals.

The findings will now be discussed in greater detail.

6. Discussion

Firstly, a summary of the findings will be presented, followed by a closer examination of their implications and how they relate to the research questions. Meaning-making is the purpose of this section, as well as highlighting areas which are significant, challenging, unusual, or surprising, and adding to our level of understanding. How the findings and implications sit within current literature will also be explored and any notable observations discussed. Findings refers to the combined results of focus group and individual interviews and the merging of the two sets of research questions; all the data will be woven together and presented as one whole.

Below, the focus group and individual interview questions have been merged together. Some questions are similar and therefore will not require examination. In this section key findings will be highlighted, demonstrating how they relate to the research questions and current literature. The wider implications of the study will be discussed later in a section.

6.1 Summary of Findings: Combined Research Questions

1. In your opinion what is mental health?

The findings show that overall, participants were well informed, having a broad understanding of mental health. However, there were some interviewees who appeared to be less clear and spoke of mental health as if it were something they didn't have. Other participants seemed to think that mental health meant mental illness, illustrated here by '... and she had mental health ...' This suggests there is still some confusion and lack of understanding about what mental health is and is not.

The wider implications being that more work is needed to educate the BMC and the black community at large.

2. How do you support yourself through times of emotional distress?

A wide range of support strategies were utilised by respondents. A number of groups, did not mention therapy and speaking to the pastor, in some cases talking to a professional or a pastor was a last resort or was not considered as an option. Some individuals made a conscious decision not to access professional counselling or speak to a pastor. The reasons given relate to negative previous experiences, poor perception and lack of trust. Most of the men in the group mentioned they didn't like talking when times were difficult and preferred physical activity such as going to the gym as a means of managing stress. The implication of these findings suggests that engaging men around their mental health needs improving, along with creative ways of disseminating information.

3. What factors affect your choice when seeking help?

Many factors were identified as affecting choice in the study and they will be discussed in greater detail in the next section. In summary, the findings demonstrated that gender was not a determining factor, neither was the racial background of the helper. The youngest participant (aged 24) made a point that she would not want an older therapist for fear of being judged and misunderstood; she was also very clear that she did not want a black counsellor. There may be several explanations for this but the wider implication is that black Christians require a range of options available to them when they are experiencing emotional distress.

4. Do you think faith and faith communities play any role in maintaining mental health and well-being?

The findings revealed that both the church and faith have a role in maintaining mental health, but participants put greater emphasis on the responsibility of the church.

Participants expressed disappointment and frustration at the lack of resources and trained professionals and ill-equipped leaders within the church setting. Also, that leaders were not qualified to deal with psychological problems. Participants shared stories of how the church has helped them maintain health but also how it has had a negative impact, discussed further in the next section.

5. How does your faith impact your health and mental well-being? And in what way does church attendance affect your health and mental well-being? (same as question 4).

6. Why do you think so many black people attend a church in the UK?

Participants responded to this question in terms of church attendance being connected to history, culture and being generational. Explanations for high rates of church attendance were the social and spiritual benefits church provides, for example building relationships, reducing isolation, collective worship, praying, singing, dancing and receiving inspiring and uplifting messages/sermons. Several participants said the experience was similar to therapy.

7. Why do you think so many black people are in the mental health system in the UK?

Participants suggested that a range of factors could lead to mental health distress, including socio-economic factors, racism and discrimination. Most interviewees cited misdiagnosis, misunderstanding of black culture and expressions of distress as the main reasons.

8. What support does your church provide to individuals experiencing mental health, or emotional, issues?

Findings show that a very small number of church-based services do exist, ranging from community programmes to counselling services. Six therapists and eight pastors/senior leaders participated in the study and expressed a wish to provide more services but were restricted mainly because their churches did not have a permanent building. The implications of the findings are that potentially partnership-working and or a strong referral network could help address this situation.

9. What help and support from the church would you find useful if you were experiencing mental health difficulties? (same as question 8)

10. How would you cope with a therapist or other service providers who did not acknowledge factors that are important to you such as faith or race?

Responses are discussed in greater detail below. In summary, the findings demonstrated that individuals faced with a therapist who did not acknowledge cultural and religious factors, were less likely to engage or continue with therapy. However,

the men in the study saw it as an opportunity to explore differences while the females said it would undermine the therapeutic process.

11. Can you identify any positive or negative effects that religious faith and faith communities may have on mental health and well-being?

The findings demonstrated that participants identified a range of benefits, with more positive effects identified than negative. Generally, people found it harder to identify negative impacts of faith although there were some contributions. Responses are discussed further in the next sections.

12. What was the group interview experience like for you?

Reflection is an important part of self-care and maintaining good mental health. Participants shared their thoughts on the group experience, which overall were very positive. The group experience inspired some participants to pay closer attention to mental health issues, including their own.

The next section will provide a more in-depth exploration of the findings.

6.1.2 Implication of Findings

The findings presented in this study have implications for mental health of black Christians, BMCs, mainstream mental health services and therapeutic services in the UK. The findings reflect the diverse and complex nature of the Black Majority Church, the challenges of wider cultural, political, socio-economic issues, the variable nature

of accessible mental health interventions and treatments, and the interplay between them all.

(See Appendix 23: Table of Combined Themes)

Major themes emerging from the findings will now be examined more closely.

What is mental health? The findings from the focus groups and individual interviews provide a compelling picture and important insights into the understanding of mental health in different arenas. With reference to Appendix 23 the overarching themes: culture, appropriate help and support and the BMC, clearly show how mental health and mental ill health are understood in different settings.

6.1.3 Culture

The cultural context reveals entrenched thinking and patterns of behaviour passed from one generation to the next within black communities; one that discourages expression of distress and release of negative emotions, but encourages masking painful and difficult experiences. Personal matters are to be kept within the family, but with breakdown of the family unit this may not always be an option for some. Lack of knowledge about emotional well-being, combined with fear of engaging with mainstream services, opens the way for the perpetuation of misinformed and inaccurate ideas. In the minds of many black people, mental health simply means madness. Stigma associated with mental ill health is another way of distancing and disengaging with the issue.

6.1.4 Mainstream/Secular Services

Within mainstream mental health and therapeutic services, good mental health is characterised by the ability to achieve and sustain a certain level of coping using resilience, talking or socially engaging, being active, making healthy life choices and so on. When an individual becomes mentally unwell the two major routes of treatment and recovery are normally through talking therapy or via the medical model; the individual is prescribed medication, or sometimes it is a combination of the two. How is mental illness understood? Conducting any assessment that omits, dismisses or underplays the significance of family, racial/cultural context and religion is problematic. A treatment plan which evaluates only part rather than the whole person is bound to be less effective.

Within the consulting room a lack of preparedness in dealing with people from different racial and cultural backgrounds can affect the therapeutic relationship. Essentially, presentations which appear different to the norm or Eurocentric ideology, are often considered wrong or pathologised. Lack of knowledge on matters relating to race and culture open the way to misunderstanding, misdiagnosis and mismanagement of the black patient/client as previous literature has shown (Cochrane and Sashidharan 1995). Within the arena of mainstream services, mental ill health is something to be cured or controlled. At the interface of cure and culture then, both are at odds with each other and neither is sufficiently addressing the mental health needs of the black Christian.

6.1.5 BMCs

Within BMCs, mental health relates to the mind (psyche); the mind is spirit. Even the early developers of psychology and psychotherapy understood the intangible and

mysterious nature of this spiritual entity, the mind (soul), although therapy has generally moved away from this way of thinking as mentioned by Jacob (1998). Within the church, mental health is hard to explain and sometimes hard to reconcile: if God is central to life, why do Christians experience anxiety, depression and severe mental illness? The assumption is that mental illness is an indication of sin/wrong-doing or of someone living above their means leading to financial difficulties and stress, or mental illness is the result of demonic activity.

When the mind is disturbed, imbalanced or broken, causative explanations include the person is taken over, possessed or oppressed by an evil spirit(s). Consequently, the approach taken to restoring balance to the mind is a spiritual one which requires interventions such as continual prayer. Mental illness becomes a spiritual problem that requires a spiritual solution. Biblical passages describing individuals who are possessed are often depicted as out of control, violent or engaging in self-harming behaviour (Mark 5:2–5). But in each story the person was healed due to spiritual intervention. However, in other less dramatic biblical examples, characters experiencing emotional distress were healed through talking or having conversation (John 4:6–29). Interpretation of scripture therefore has huge bearing on how mental health is tackled within the church.

Limited understanding of mental illness, narrow views on causes of mental distress, insufficient training, resources and signposting can all lead to inappropriate and damaging interventions, due to a 'one size fits all' approach; that is, over-spiritualising problems. Nevertheless, if churches are seeking to embrace a holistic approach which includes, that we are spiritual beings, it stands to reason that some problems will have spiritual roots, it is therefore reasonable for such problems to be

addressed in a spiritual way. However, this method is not recognised by psychiatric services as cited by Bhui and Bhugra (2003). This would require careful assessment and discernment to make the right judgement. Without an appropriate level of knowledge and skill, any attempt to gauge the root cause of any problem will potentially cause harm. In the absence of this expertise and skill, the black Christian often resorts to 'self-care' and is left feeling let down by the church.

6.1.6 Socio-economic Factors

Central to the study is the black Christian's position within society and within the church context; two different worlds, with different expectations, competing goals, and distinct perceptions of the black Christian. The main themes developed from the study highlight some of the challenges facing the black Christian as they co-exist between these two arenas. Generally, on the positive side, the church experience can be empowering, vibrant and affirming, encouraging members to progress and overcome barriers. However, 'in the world' (secular) there are many factors which impede personal growth and development such as: poor availability of choice, access to healthcare, career progression and lack of opportunity. Inevitably, this will impact upon self-confidence, self-esteem/worth and mental health.

6.1.7. Maintaining Good Mental Health

Being black and Christian present certain challenges to a wider society that is increasingly moving towards spirituality and secularisation, and therefore struggles to accept or understand difference (in this case Christianity), although some will 'tolerate' it. Racism and discrimination is inherent throughout all major institutions in society, combined with wider socio-economic factors such as poverty, poor educational outcomes, limited employment options and family breakdown,

unsurprisingly, well-being and quality of life will suffer, and impact negatively on mental health. Studies support the notion of mental health problems manifesting in physical forms (NHS Choices, 2017). This understanding of the mind-body link is important with regard to maintaining good health and will invariably affect lifestyle choices. In addition, the black Christian navigates through the two worlds having to get to grips with the (unspoken) rules, receiving different messages from each: church says 'you can', the world says 'you can't,' church says 'you can have it,' the world says 'you don't deserve it,' church/The Bible says 'no' the world says 'yes' and vice versa.

The health of the black Christian then, is determined by many internal and external factors, and the task of staying mentally and physically well is not an easy one to achieve and maintain. Generally, the black population is more prone to developing certain serious health conditions such as hypertension, prostate cancer and severe mental illness. Black people are less likely to engage with medical services and when they do, the risks of misdiagnosis and inappropriate treatments increases. All this can lead people to disengage and ignore important indicators of illness. Although most BMCs advocate healthier lifestyle choices such as no smoking, no/low alcohol consumption, celibacy and fidelity, the onus is on the individual to look after themselves.

The black Christian's engagement with their own health and well-being can be charted along a simple 'passive _____ proactive scale.' Depending on where the individual is situated along the continuum, determines levels of ownership and personal investment into maintaining good health. The passive individual is likely to be reactionary, be less informed, placing greater emphasis on

others for help and will rely heavily on being told what to do. Conversely, the proactive individual takes greater control of well-being, it is an active process, they are more self-reliant and better informed. Faith communities will have individuals positioned across the breadth of the continuum and therefore has an opportunity to become important information hubs for prevention and treatment of health conditions; the church can make a significant contribution to the well-being of congregants. Consequently, this knowledge can be passed on to non-Christian friends and family members, thereby impacting the wider community and challenging stigma and apathy.

6.1.8 Identity

How the black Christian defines him/her self is equally important to mental health and well-being. The competing messages from the church and world can contribute to the process of identity-shaping in both positive and negative ways. Interviewees describe church as providing spiritual, social and practical support, and promoting self-progression, strong identity, purpose and a sense of belonging. All have of which have been cited as positively contributing to well-being, and the health benefits relating to reduced anxiety and depression for example, have been widely researched. In this sense the findings are consistent with current literature (Akhazemea, 2015). However, some responders reported church as being a hostile, punitive and an unsupportive environment to individuals with mental health difficulties (and sometimes to those with none), a place where individuals cannot be themselves, but are expected to conform or risk being alienated. This has undertones of members feeling controlled; in addition, the black Christian is worshipping alongside their aggressor; those who are judgemental and disapproving.

Life outside the church walls can be explored in terms of equality. As UK citizens, black Christians are entitled to the same rights and privileges as everyone else, which includes aspiring in whichever chosen field or occupation, and where hard work is rewarded financially and through promotion. Within the work environment, neighbourhoods, educational establishments, excelling and enjoying success is not straightforward for black people in general. Effort and ability do not always pay off and there can be a sense of being held back or controlled. This particularly relates to black men, reflected in responses given to the research question, on why there are so many black people in the mental health system. Often the black Christian is living, working and studying alongside their aggressor who is seen to be hindering progress.

The predominant message from both sides – church and world – is that the individual is not good enough. Gender-specific stereotypes, such as ‘black women are aggressive’ and ‘black men cannot commit’, the changing roles within the family unit, the increase in fatherless households and other factors, all contribute to huge challenges of daily living. In contrast, participants spoke of feeling the love of God which could translate into ‘being good enough’. There are many competing voices with conflicting messages; processing the information, deciding consciously or unconsciously whether to accept, reject or be indifferent toward the messages can require huge effort on a daily basis. This constant internal processing was described by several participants, for instance: in reaction to the warring with what God says versus personal desires; in church hearing positive messages from the pulpit but not seeing them materialise, and being ‘experimented on’ by psychiatrists.

6.1.9 Religious Coping

The results demonstrate overwhelmingly that, in times of difficulty, participants used religious coping as their main strategy. Self-care or self-help came in the form of prayer, reading The Bible or specific scriptures, listening to gospel songs and singing, exercising faith as well as attending church even when it felt difficult to do so. Participants spoke of how the message or sermon was exactly what they needed to hear at that time, and others reported feeling better immediately in response to a sermon or as the service progressed. Problems were suspended and wisdom sometimes provided answers. Possible explanations for this may be found in the therapeutic process. In very simplistic terms, during a session the client talks and releases emotion which may result in them feeling unburdened and better by the end of the session. Likewise, when participants pray or talked to God, shared thoughts and feelings, and released emotions, they too unburdened themselves and were left with similar positive feelings. Previous neurological research supports the findings regarding emotion and brain activity (Newberg 2010; Davidson 2012).

6.1.10 Faith

Unequivocally, the findings show that faith played a huge role in maintaining mental health and well-being. Participants reported feelings of hope, strength, comfort, peace and 'a knowing'. Studies in the literature review corroborate these results (Duncan 2012). 'Knowing' is significant in that it is a personal, subjective knowing. Knowing was expressed as the reassurance and confidence in God and in His ability to change difficult circumstances, and the belief that things will work out for the better. This may sound similar to positive thinking and optimism but participants argued it is much more than that, knowing is 'untouchable' as one participant said, 'it's deep on the inside'. Knowing stems from a personal relationship with God as

several participants explained and involves having encountered experiences and situations which are attributed to divine intervention.

Accounts from interviewees that without faith they would be dead, or their situations would be worse were striking and a clear demonstration of the power of faith and its 'buffer' tendencies as described by Wink et.al. (2005).

Faith can also impact negatively on mental health. When participants spoke about faith they often interchanged it with church so it wasn't always clear whether faith was actually the issue. Nonetheless, faith can cause challenges, faith in God requires the black Christian to adhere to biblical principles and values which sometimes clash with personal values and behaviours.

6.1.11 Self-care

Participants in the study provided text-book examples of the various mechanisms used to support themselves in times of distress, from walking to exercising and journaling. Also, among the list were meditation, gratitude and forgiveness; components of mindfulness practice (British Mindfulness Institute 2017), which are part and parcel of Christian living. Unwittingly, Christians have been practising (the now newly termed) 'mindfulness' since the introduction of Christianity, and have therefore been contributing to their mental health for centuries. Self-care is a theme which interconnects with most of the main themes in the study.

Self-care can take three main forms according to the findings: 1) Self-care which involves no other person or service. Here the Christian relies on inner resources, tried-and-tested tools, learning gained from past experience, positive affirmations,

and spiritual support mechanisms such as hope, prayer, music, dancing and faith, and simply taking life as it comes. A further split within this group shows there are individuals who feel sure they will come out the other end of a difficult situation because everything happens for a reason, and God is in control. The root cause of the problem is likely to be attributed to a range of factors including: spiritual, psychological, financial and so on. The other side of the split refers to those who are coping in isolation but who are not as hopeful, they may well be confused as to why certain negative things are happening or simply feel overwhelmed, they may also decide to suffer in silence. The root cause may well be ascribed to spiritual forces, which is often used to define the inexplicable.

2) The second type of self-care describes individuals who rely on friends and family for support and avoid engaging with any external services including interventions offered by the church. Problems may be interpreted as stemming from a range of factors and family and friends provide insight, encouragement and solutions.

3) Self-care in this group involves a combination of approaches including self-help, friends and family and the use of external agencies. Individuals may decide to utilise only secular services or rely solely on support offered by the church, or a combination. Causative factors may be considered the result of chemical, psychological, behavioural problems, or may be connected to physical or work-related issues. These types of issues are more likely to be brought to a mainstream counsellor or mental health professional.

Church leaders, however, are often approached with a whole range of problems from relational, domestic situations, concerns about children to exams and prayer for job

interviews. In particular, when the individual believes the root cause of the problem is of a spiritual nature, the likelihood of seeking help from the church increases.

6.1.12 Leaders

Participants highlighted the huge responsibility placed on church leaders; their elevated position, spiritual endowment and insight, cause some members believe that leaders have the ability to solve or cure all problems whatever the root cause. One participant pointed out that black Christians should be more realistic about what leaders can and cannot do. Given the demands placed upon leaders to provide answers, where does divine endowment end and equipping oneself begin? It also raises the question do leaders set themselves up to fail by declining to speak about their own mental health challenges or not showing vulnerability? Lack of openness and transparency may lead to congregants expecting too much. Powell (2016) confirms this in his study on pastors and found church members were more likely to be open about mental health if the leader was also echoed in the findings of this study. Findings confirmed that participants felt a greater emphasis on signposting would help ease the burden placed on pastors and could reduce the number of inappropriate interventions. Unavailability and inaccessibility of leaders due to busyness and managing large congregations, could cause some members to feel abandoned in time of need; lack of access to the leader may trigger feelings of frustration and in some cases can result in the individual leaving the church, as one participant recounted.

The small percentage of senior pastors willing to participate in the research reflects how challenging it is to engage leaders in discussion about mental health. Pastors who were open to learning were more proactive and supportive to their congregation

than those who were not; proving training is essential if leaders are to be effective in this area.

Moving forward, senior leaders in this study will play a vital role in modelling the benefits of training, partnership working, self-care, supervision and peer support. BMCs are rarely totally independent, they are normally part of a network of churches, which provides an ideal opportunity for informed pastors to address the anxieties of their less-informed ministerial colleagues by sharing knowledge, information, signposting and motivating colleagues to embrace training and support.

6.1.13 Factors Affecting Choice

Where the black Christian is positioned along the passive____proactive scale, whether or not they are able to quell the internal and external voices, whether or not they have a strong sense of self, and depending on the interpretation of the problem and perceived root cause, will all influence the level of self-care including the means by which help is obtained and the type of support accessed. Findings show a wide range of factors affect choice in times of distress. According to the self-help categories mentioned above, if the individual is suffering in silence, help may come at the point of crisis. The type of support received will be depend on whether the help is secular or church-based. When a black Christian is in crisis and is relaying their story, how is it heard or interpreted? Studies demonstrate that diagnosis of religious delusions are made on the basis that the person is relaying their problems in religious terms which mainstream professionals may not understand. Equally, if an individual approach a church/pastor with a chemically or psychologically related problem, what is the pastor hearing? The pastor is more likely to spiritualise the problem and suggest prayer as the antidote.

Overall, the findings showed that participants felt church had more of a positive impact on mental health than negative. However, on closer examination of the findings, the elements which impacted positively were collective activities such as worship, singing, prayer, social and community-based functions and relationships. Gaps in psychological support had a negative impact on mental health and therefore would impact on the individual seeking help from the church in the future.

Experience and perception are also determining factors when the black Christian is seeking help. Personal experience or knowledge of friends or family members taking prescribed medication for mental health difficulties and the impact of this, may deter the help-seeker from conforming to medication regimes; they may refuse to take medication altogether, relying purely on their faith for recovery. This of course can have serious consequences, but the leader's opinion on medication may also lead to non-compliance, based on whether taking medication equates to lack of faith as demonstrated in the findings and endorsed by several participants in the study. Equally, if the Christian is told the only solution is prayer whatever the problem, this can lead to levels of frustration with the church if the situation doesn't improve and may drive help-seekers to find other forms of support externally.

Other factors affecting choice, such as cost, time and waiting times have some bearing on the type of help that can be accessed external to the church. One unanticipated finding was that overall, gender was not a major deciding factor, however one male participant mentioned that he preferred talking to women whom he found listened more.

6.1.14 Counselling and Psychotherapy

Between them, participants had experienced a range of therapeutic interventions, including psychotherapy and cognitive behavioural therapy, with positive outcomes overall. Therapy comes under criticism in the study if the therapist does not acknowledge factors such as race and religion. The male participants did not appear to mind this omission, suggesting it was an opportunity to hear a different perspective. Female participants however felt it would undermine the counselling process and impact negatively on the work. One participant expressed that she has in the past, and would again, terminate sessions. Implications of these findings have some bearing on course design and delivery of training programmes. It demonstrates the importance of trainees and practitioners in general, being equipped and feeling confident enough to broach issues relating to race and religion in the consulting room. This is reflected in the literature review NHS (1999); We Still Need To Talk (2014).

This study found participants were fully supportive of in-house counselling services, or alternatively simply having access to counselling. This issue was raised in every interview and the responses were consistent. From the findings, participants identified a gap in church-based therapeutic provision and felt it was paramount this lack be addressed. However, it was reinforced on numerous occasions, that any psychological intervention should be conducted by fully-qualified professional therapists. Equally concerning to some participants was being assigned a trainee when they received therapeutic help, as the experience and outcome was less than adequate.

The implications of this suggests a level of competency is required alongside sensitivity, and as interviewees suggested, personal qualities such as being friendly. Participants were aware of codes and standards associated with professional counselling and several participants stressed the importance of confidentiality. As the findings show, embedded within African-Caribbean culture is mistrust of others who are external to the family circle. Mistrust also stemmed from hurtful and damaging past experiences at the hands of leaders and mainstream services. Therefore, some participants would not embark on counselling without researching the helper first; a thorough search on the individual and where possible and/or observing them from a distance. It was clear to some participants that if they didn't feel comfortable after meeting a counsellor, they wouldn't go back. Several participants suggested therapy groups would be a helpful alternative to individual counselling, one participant in particular pointed out that groups provide additional support as well as different perspectives.

In addition, participants stressed the need and importance of maintaining boundaries when counselling services are in-house. Ideally congregants should be referred out but with limited alternatives, especially if the member requests a counsellor who is a Christian, meant some counsellors and clients attended the same church. Some participants said they found this uncomfortable and expressed the need for signposting to external services and partnership working.

6.1.15. Qualities and Skill

Findings of the study identified key qualities and skills that a helper/helping service should have: be professional, genuine, friendly, kind and non-judgemental, and have good listening skills, criteria applied to both secular and church-based services.

Participants felt there should be no difference in the standard and quality of service they received, regardless of whether it was offered by the church or externally. This has implications for leaders and mainstream services to be sufficiently trained, to acquire relevant knowledge and skill to effectively and appropriately engage the black Christian.

6.1.16 Partnership-Working

Findings show participants felt that secular and church services could work together, supported by previous studies and various reports. The challenge partnership presents are within external services there may be a lack of cultural sensitivity and religious awareness, increasing the risk of pathologising, resulting in inappropriate interventions. Hence the implications of the findings are that partnership-working should incorporate mutual respect, openness, a willingness to learn about different beliefs and practices. Churches too must overcome their distrust of mainstream services. Findings also highlight that as part of partnership-working, effective referral systems should be in place. Implications are that referring should work two ways so both mainstream and church services would need to assess when it was appropriate to refer to each other. This requires a level of understanding, working closely together to create effective service level agreements with clear parameters, roles and responsibilities.

Some participants spoke about therapeutic services that were established in their churches. One participant highlighted that, although there is huge enthusiasm when new initiatives are being introduced, often the uptake is poor. Another participant suggested that the process of accessing services needs to be more discreet. The implications then are that much thought and collaboration are required when services

are being set up and advertised. Perhaps if the church culture worked towards normalising mental health issues there would be less discomfort surrounding access and promotion.

6.2. The Social Care Model

Participants who attended a community centre in South London spoke unceasingly and with huge gratitude about the help and support they had received. The centre demonstrated the importance of holistic care. This was echoed by other participants in the study who suggested that when individuals approach the church for help, a care package should be put in place which takes account of social, economic, spiritual, psychological and practical needs. The centre seemed to be a cohesive community or family, and used the social action model which is collaborative, empowering, practical, caring, educational and supportive in its approach.

Previous writers have stated that black people are experts on their own mental health and should be given the freedom to formulate treatment plans that are more culturally sensitive, less medicalised and have a greater emphasis on therapeutic and social interventions. One participant felt that BMCs are missing an important opportunity to show external agencies, not only how they have assisted members with mental health distress in the past, but with training, increased knowledge and greater understanding they are best placed to demonstrate the most effective support programmes that work well for black Christians and the wider community. Another participant highlighted the lack of senior practitioners within the field of therapy and mental health, and the limited amount of material written by, and available to, black people. This participant felt strongly more culturally-sensitive material to be made available.

6.3 A Safe Place

Black Christians, when experiencing emotional distress, are often seeking a 'safe place' as described by one participant. This place is one that is supportive and allows exploration of thoughts and feelings without judgement.

A safe place implies no deliberate harm will come to the help-seeker, where one's rights and dignity are respected, as well as their autonomy. Safety cannot always be found in the community, where the rules may differ, and ways of coping are often at odds with Christian values and ways of dealing with situations, for example use of violence or over-reliance on alcohol. A safe place sometimes cannot be found in mainstream services where Eurocentric approaches dominate and racist practices remain entrenched and unchanged. Neither can a safe place always be found within the church setting where helpers are ill-informed, untrained or applying a uniform approach to all problems. For many participants the safe place was within their faith.

6.4. Looking Forward

From Ignorance to Insight

According to the Collins Dictionary, ignorance means blindness, lack of knowledge, inexperience, unawareness, oblivious. Blindness and obliviousness particularly resonate with me with regard to the findings of the study; blindness refers to 'unable to see' and oblivious means 'deaf.' I approach this section cautiously, as it is not my intention to present a negative image of BMCs. Undeniably, the church has provided (and continues to provide) spiritual and psychological care to members, often with no additional input, government support or resources. BMCs have stood the test of time, withstood changing political and social climates and have been a place of refuge and

restoration for many members of the black community. Despite these huge contributions, participants in the study are urging for a more holistic approach which encompasses both spiritual and psychological interventions.

However, sometimes ‘we don’t know, that we don’t know.’ Until we are enlightened, we remain ignorant and in the dark. Mental health issues are present within the church but some leaders are blind to it, so problems are addressed spiritually. When participants shared their stories, some Pentecostal leaders became deaf to their distress and applied the same spiritual formula – prayer. There might have been a genuine belief that this is the only answer to the problem. This study is not anti-prayer, previous studies clearly show prayer is an important coping strategy and buffer especially to those experiencing physical or mental illness. But the study seeks to explore additional forms of help to work alongside prayer or in conjunction with it.

The fact remains that healing can be achieved in many different ways, including acquiring knowledge, empowering oneself, training and therapy, which are other forms of self-improvement. The black community too, exhibits a level of ignorance by distancing itself; becoming blind and deaf to signs and symptoms of ill-health (sometimes their own). Mainstream services have become blind to cultural needs and deaf to the calls for change within treatment and therapeutic services.

Moving forward, the aim of the project is to use products developed over the doctoral journal, to impact directly upon BMCs by facilitating a shift from ignorance to insight. Insight refers to vision and understanding. Leaders will receive training to enhance their level of understanding, and by acquiring key skills build confidence, improve communication and gain the ability to recognise signs and symptoms of mental

health distress, as well as referring appropriately. It is hoped this will motivate leaders to work towards creating a more inclusive and supportive culture within their churches.

6.5 Products and Reflections

(See Appendix 24: Participants' Description of Barriers to Seeking Help)

The study provides compelling evidence showing the limitations to current therapeutic service provisions available to black Christians. At the start of the research process, I was unaware of the extent of the problem and set out with a sense of curiosity to explore current provision in terms of quantity and quality. The situation is much more serious than I imagined, which led me to revise some of the original products, for example, development of certificate and advanced training courses to focus on more pressing initiatives.

Throughout the life of the project a range of products and services have been developed, each has been designed to address an area of concern raised by participants in the study. They are discussed below:

6.5.1 Radio Show

At the beginning of the research journey I was a guest on several radio show programmes, discussing issues around mental health and personal development. One of the presenters suggested I have my own show because listeners wanted to discuss emotional issues. I went on to create a show called 'Speak Your Mind' on Ruach Radio, an award-winning 24 hour Christian station. The talk show discusses mental health issues using biblical and psychological principles and simply provides

information on: what mental health is; signs and symptoms of mental ill health; how to maintain good mental health and where to help. Weekly guests are invited to share their expertise on a range of mental health topics such as dementia, body dysmorphia, depression, anger and so on. Christian professionals, including nurses and doctors, were invited to discuss a mental health-related subjects.

The exchange between Gideon and Hannah below, reinforces the importance of knowledge, raising awareness and how this motivates people to make better health choices.

Gideon: and it's a big church of about close to 700 people alright. I have it or maybe I'm just having some off day and you know, and so I wouldn't check it out [mental health issue] to see actually, because the moment I notice what I have then [says his name] gone mad, and so the whole church runs with this ...

Hannah: Again, it's awareness and making people knowledgeable about the subject, so that they can know how to handle situations like this. I mean people who if, if you used to do something one way and you realise that there is a better way of doing it, then you will want to learn the better way.

The radio show provided a platform for disseminating information to individuals by capturing a wide audience. The radio station has international coverage with a predominantly Christian listenership of 6,000, over 4,600 friends on Facebook and 5,210 friends on twitter. I also saw it as an opportunity to demonstrate that there are many black professionals who are Christians with insight into mental health issues.

Guests came from different churches; an ideal opportunity to build relationships, partnerships and learn about expertise within the faith community. The impetus for the radio show was simply to educate through information and discussion, and to normalise and de-stigmatise mental health within the faith community. Recordings of the shows can be accessed via the Sozo Therapeuo website www.sozotherapeuo.com. The show has been running successfully for two years.

6.5.2 Sozo Therapeuo

Sozo Therapeuo is a resource I developed to promote, improve and maintain good mental health within the churches, achieved through information, education and therapy. The name originates from two original Greek words found in The Bible:

Sozo – To heal, save (oneself), make whole (Matthew 9:22; Mark 5:23; Luke 8:36)

Therapeuo – To serve, cure, treat, heal, restore, worship (Matthew 17:16; John 5:10; Acts 28:9)

(Sozo Therapeuo is not connected in any way to any similarly worded name or organisation).

The focus group discussions and individual interviews highlighted concerns and a deep sense of dissatisfaction with the type of help and support currently available to black Christians. This inspired me to address some of these issues by developing 'solutions' and alternatives. The extracts below represent some of the conversations which helped to formulate my ideas and resources.

Wendy: ... in terms of counselling my observation is, I just don't think people are qualified. I don't want to come to you and tell you that I have this emotional or mental issue and you tell me to fast and pray about it because ... and this is where I think the church and mental health ... we're just missing each other in Christ. This is my belief. Christ came for the whole man. He came to minister to us holistically whether its spiritually, emotionally or physically. I believe that church, in my experience hasn't really given any time or effort into the mental side of God's ministry to us. We think about what we put into our bodies, don't smoke, don't take drugs, yeah we all know that, we know ... the spiritual prayer, fast, you know none of these things can be done without praying or fasting those are the two keys to open the door ... I can give you all the clichés you know, sorry to call these words of God clichés but people say it so much its now become a cliché but no one's actually taken the time.

Vanessa: (A pastor) I began to build my vision of what church should be, and my vision of what church should be is nothing like the experience or the church we're used to. And I put things like, umm, managing your money classes, cooking, cookery classes, using the brethren available to do cooking for the community, Macmillan, you know, like coffee mornings where it's open. I put in crafts classes, day class, all things like that. Library, Christians to bring in their old books so we can have a library, we can have a little library system, so it's for everyone. I put in tables and chairs for like a little cafeteria, they were at the front

where it's open, that's what I put into it. But I think that's really, really important, we tend to preach to ourselves, and we're insular, I think the church is very insular. And I think the reason why we're not bigger, better is we don't, we don't utilise our professionals.

The emphasis here is a holistic approach which addresses both spiritual and practical needs. It prompted the development of Sozo Therapeuo, its aim being to address the whole person in terms of mental, physical and spiritual well-being.

Sozo Therapeuo provides bespoke training packages, information and access to counselling services primarily to BMCs. A range of resources are linked to the Sozo Therapeuo website including the Therapist Directory (discussed below) and access to photographs and testimonials of previous training events. In addition, the website will be used to promote upcoming events. Christian-based support services can be accessed from the websites as well as helpline numbers for non- Christian support services. In the long-term the website will become more interactive as the service develops.

This initiative was developed in response to lack of training among leaders/leadership teams and them being insensitive and ill-equipped to manage mental health distress within BMCs, this is demonstrated in the following excerpts:

Yasmin: ... but it's taken me years to actually feel like its ok, I can be depressed and a born-again Christian. I've had church leaders tell me 'No, you should be saved, God loves you, you're not praying enough,

you're not fasting enough,' and you fight that. You think you're ... you become double-minded because, and a double-minded person is unfaithful ... the church leaders who I look up to for teaching and guidance, all I need is someone to turn around and say 'you know what, what you're saying is valid, however I can't help you but I can signpost you to someone who (can) ...

Brenda ... some churches do have counselling services, which is great, but we need more, umm, also as well, our leaders need more training, umm it's great being spiritual about things, and for anybody that knows their Bible that knows the Word – we can relate a lot of what we go through to several people and several situations in the Bible. At the same time, if I'm honest there are times when I don't want to hear what the Bible has to say, I just want, and that's not me being ungoldly, you know. If I've got a drink problem please don't tell me X just pray [group laughter], I don't wanna hear that, I want you to explain to me what this is doing to me in my mind and in my body and in my spirit. Because then when you explain everything as best you can and help me to understand it then I'm more likely to make a quality decision about my life, about my connection with God and other people and, but I really believe that you know, for congregations that are blessed with leaders who understand, yeh not every congregation is blessed that way.

Frank: For me, when I was going through my distress, it was very distressing, you know the depression, the anxiety disorder, the panic attacks. I had

nobody to talk to in the church because nobody had the understanding, because of what I was going through from an emotional, psychological and mental perspective, everybody was spiritually based, so everything was spiritualised. Everything, every issue, every problem was spiritualised. They forget that you're a soul which has a mind, emotion will and also a physical body and they just focus on the spirit, which is the conscience, intuition and the communication, they just focus on that, and so that is the reason why they will [drum] it into you [that] God will fix it for you.

Leaders or church members can approach the service for signposting, information and training. Sozo Therapeuo will design and deliver bespoke training programmes to meet the needs of individual churches. I am already delivering training to the church community; pastors have specifically requested Mental Health Awareness training for their churches.

Delivering training has allowed me to have meaningful conversations with pastors about mental health issues. By supporting pastors and providing referral options it sends a clear message that psychological problems should be addressed by professionals. It also encourages open dialogue which in turn can reduce stigma. My use of Biblical passages which acknowledge and support mental health have also been an effective way of engaging churches/leaders because they recognise the language.

The resource helps to raise awareness in the church which invariably will impact the wider community as black Christians pass on the information to friends and family.

It was clear from the interviews, participants want access to professional counselling that is sensitive to their racial and religious backgrounds. This shows black Christians are willing to explore their psychological and emotional concerns in the right environment, which is very encouraging. If within every black person is the genetic memory of slavery, then black Christians (people) should be encouraged to explore the impact of this. But it raises the question of who can adequately meet this demand.

One link between high numbers of people attending churches and the high numbers of black individuals in the mental health system is that perhaps the numbers in the mental health system would otherwise be much higher. Far more people would experience crisis – given the racial and socio-economic challenges black Christians/people face on a daily basis. So, is faith in God the means by which black Christians avoid crisis? Existing literature and findings from this study seem to suggest so.

6.5.3 Training for Leaders

(See Appendices 25 and 27 for Training Day Programmes).

(See Appendices 26 and 28 for Summary of Evaluation Forms)

Participants emphasised the need for those providing support to be trained, reflected in the exchanges below:

Susan: I don't know, I don't know how long, but I would know, I think I would know when I felt the time was right to think, OK, maybe I could go to them [a church-based counsellor]. But I do think it's important to have

training, I think it's so important, and I think that's where a lot of the issues in the churches [stem from] because they ...

Vanessa: ...they weren't trained.

Susan: They weren't trained; they didn't know, you know, they just like, you know, try and help somebody, I think that's how they did it, but I think the theory and the training, the understanding of what they're doing is so important.

Wanda: And I think they need to, they need to be respectful of the confidentiality, that's a big, that's a big [part].

Researcher: So, are you saying there's a difference, are you making a distinction between pastoral counselling and professional counselling? Do you think they're the same?

Susan: I think they should be the same.

Anne: If it's pastoral then they should have that same level of professionalism and, and ...

Vanessa: I would expect more, they'd have that extra.

Wanda Yeh, they'd have that extra and ...

Anne: The church will have spiritual guidance. But on top of that the qualifications, the professionalism, the persona, the ability, do you know what I mean?

In response to some pastors not being adequately trained, I developed and piloted two training workshops, the first of which was 'Mental Health Awareness for Church Leaders' followed by 'Counselling Skills for Pastors and Leadership Teams'. They were designed in response to accounts shared by participants who had approached leaders for help, and were left feeling worse, or in some instances damaged. To provide leaders with training would help to reduce risk of harm to congregants, unwittingly or otherwise.

The training sessions were free events and lunch was provided, as an incentive to boost attendance and to promote the service. I recruited a team of administrative staff to assist with planning and organising the events. I invited therapists and leaders from other churches to co-presenter. By doing so, the formation of a network of therapists was established, some had previously appeared on the radio show.

Again, this allowed the faith community to see joined up working across denominations and so see the level of expertise within the team.

This product aimed to empower leaders through education and developing skills. The aim of the workshops was to: provide information and skills to assist leaders in recognising the signs of possible mental ill health; to provide tools to promote good communication skills when engaging with distressed members; to build confidence in signposting and referral processes. The training events were specifically aimed at church leaders and were a way of directly addressing the concern that generally, pastors were not sufficiently equipped to deal with mental health/psychological issues within the church. The training approach was a combination of information sharing, experiential exercises and times for personal and group reflection. There was also the opportunity to network. The training brought pastors together in a safe environment, they were able to share and learn from each other, and many realised they were not alone in their experiences. The wider impact of the training is that leaders who attended the event were enlightened and left better equipped to addresses mental health issues. Several leaders committed to paying closer attention to their own mental health needs also. It is hoped the impact of the training will not only be felt in the churches but in attendees' homes and their wider church networks.

Further information can be accessed at: www.sozotherapeuo.com

6.5.4 Training Manuals

(See Appendix 29: Training Manual - Mental Health Awareness for Churches)

(Appendix 30: Training Manual - Counselling Skills for Pastor and Leadership Teams)

The next two extracts directly inspired the development of this product. I understood that some pastors would not attend training but may prefer to read printed material. Writing about how to manage mental health might help pastors and leaders avoid the damage caused to congregants through ignorance and inappropriate interventions.

Frank: ... in churches, what I can draw from that is some of the negativities is being judged, being stigmatised, being labelled, being umm, umm quashed, or how you want to put it, silenced, not being able to talk about the situation you know, being identified as weak, and so therefore it discourages, it demoralises and you feel unappreciated or undervalued as a human being, and because of that it's difficult to share what is really going on. So whatever you share it's like you're, it's like a shadow of what's happening, a façade, you stay on the surface, you're not going deep and because of the way the church might – I use the word 'might' – respond because, to bear this in mind it's not every leader that will respond that way, but there are members within the congregation or within the ministerial or pastoral team that will respond that way. Because what has been said before is that I believe a lot of leaders need training in these areas, they can apply and identify what is not just spiritual ... these are stuff that is coming up because of various bad traumatic experiences in our lives.

Liz: There are insufficient black consultants, policymakers, and books on mental health from a black perspective to increase awareness and bring about change.

Alongside interviews and feedback from the training workshops, I designed two training manuals: 'Mental Health Awareness for Church Leaders' and followed by 'Counselling Skills for Pastors and Leadership Teams.' The manuals were created using biblical and psychological principles (as was the training) and are a mental health resource for churches. The intention is that the manuals will serve as a guide and reference for all those within the church setting, who may encounter someone experiencing mental health distress.

The manuals are designed to be used in conjunction with the training sessions or as a stand-alone resource. The manuals are comprehensively written and are interactive with practical exercises and points for reflection throughout. This product addresses the point for more resources to be made available to churches and that more information is needed so individuals can support themselves and others more effectively.

6.5.5 Therapist Directory: Qualified Practitioners and Practicing Christians

The creation of the Directory of black qualified therapists who are practising Christians was something I had wanted to do for some time.

Counsellors, psychotherapists and psychologists send through details of their private practice or counselling organisation including accreditation and membership details. This is uploaded onto the Sozo Therapeuo website and is easily accessible by all.

In phase one I am aiming for London-wide coverage counselling provision and in phase two, national coverage. As far as I'm aware this is the first Directory of its kind.

The following participants demonstrated the need for this resource:

Yasmin: ... it just annoys me in that I went through years and years of not being counselled the right way because I think you should be ... I think people should be qualified. You can't just say you're a born-again Christian and think that qualifies you to be a counsellor. Yeah, you're qualified by giving me Gods word and to speak over my life but you can't tell me how my mind works and the things that I should do. You can't tell me about cognitive therapy or therapy; you can't look at my state of mind and tell me what is going to work for me because you're going to tell me fast and pray which is right, we should do that alongside ... so I'm annoyed.

Liz: [What support services would be useful?] There is someone to talk to in a 'safe-space' with available resources and signposting.

Rochelle: More trained counsellors on mental health issues, more patience and understanding, less fear, less stigma, less judgement, less gossiping.

One of the participants in the study did not want to see a black therapist and this reminded me of my early experience as a therapist, when a black client refused to see me because I was black.

Debra: So, it was way outside of my local area, not black, I didn't really care if it was, male or female, just as long as it wasn't black [therapist].

When individuals are looking for therapeutic services, it is important to provide a range of options and avoid a one-size-fits-all approach. Not everyone will want to see a Christian, or a black counsellor and that must be respected. This resource offers those individuals who do want a therapist who is black and Christian. Individuals can self-refer to professional counselling services available across the capital and eventually on a national level. The intention behind this product is to provide Pentecostal Christians with greater choice when they are seeking help and support. Equally, this provides churches with more referral options. This is an attempt to help address the gap in service provision. Currently there are few black Christian male counsellors, however, this reflects a similar picture within mainstream services.

6.5.6 Church-based Therapy Forum

This initiative came about as I was writing up the project. I was reflecting on some of the participants who mentioned therapeutic support was offered in their churches. I thought it would be effective for these services to connect in some way; to provide support to services already working in isolation. Representatives from church-based counselling services have been invited to meet on a quarterly basis in a confidential space to: discuss current issues, receive peer support, share resource and good

practice and training. The aim is to facilitate joint events, provide a network of support, reduce counsellors working in isolation, to create a referral network, and to ensure all counselling services are practising to the same ethical standards.

In the next exchange the speakers highlight different areas associated with church-based therapeutic services which had a direct influence on the development of this product. Firstly, Frank highlights the challenges around premises:

Frank: Therefore, for me, my church does embrace it [therapy]. I would love, it would have been nice if there was a counselling service in my church and It's not because we don't want to have one it's simply because it's not our own building.

Next, participants talk about initiatives and services in their own churches:

Priscilla: But now, praise be to God, in the last, I'd say in the last five years we've started to look at things differently and, praise God again, in our church we have a pastor or an Apostle who listens. So if we come up with a new idea, and we say look, we think we should do this, he says go ahead, or he'll say let me pray about it first and then let's try. There's no taboo and he doesn't say no and we have started this our project in the last, I'd say in the last year we've been running this ... people don't want to put to their hand up and say, 'I'm struggling here' including myself. I'm struggling, I need some help because we still have this, there's a stigma attached to mental health that we still hide behind the curtain. They will think I'm losing my mind, they will think

I'm going crazy, so I'm gonna keep this to myself and muddle through ... we started this project ... we've made a bit of inroads, kinda cracked open some, opening up some wounds, maybe caused a little discomfort to people, but I think in fact, I think it was good because they then opened up of their own accord. So, the congregation said, *I went through this, I went through that, I went through that but praise be to God this is where I'm at now.*

Rebecca: ... the field that I work in, like what you were saying earlier, why so many young men, so many people have gone into hospital, I think to myself and I work with people with ongoing mental health issues. And so, we took this, we went on a course and we came back and we said, OK, we hit the ground running from day one. On the course ... we had an exercise, and it just opened my eyes to, um, we had a smiley face at one end and a sad face at the other end ... we just really didn't realise the thin line that bordered sadness and happiness, and so we went back and that was the first exercise we did at church, and was wow, young people wow! Older generation wow! And so when we did the study [a survey], people were like, we should have more of this, this should have started many years ago, but nothing happened before ... So it's understanding; it's knowing that although mental illness is a big, it's a huge umbrella ... I t's letting people know that there are different strands, meditation or therapy or counselling or whatever it is ... out there. Be aware that they're out there. It's awareness.

Researcher: You call it a project; does your project run over a period of time?

Priscilla: We have, every Sunday, we have a twenty-minute slot after service.

Collette: I was just going to say that it is, trying to answer the question in terms of what churches do, as I mentioned before, we do have a counselling service and as a team of counsellors we go each month, we take a service each month and we go to the different churches, umm, the churches will tell us what the issues are and then we tailor the programme to whatever the issues are. Sometimes we'll have, like, a surgery at the end of the service so individuals will come and see us on one to one and then we kind of direct them to the counselling service, and that's generally where, we get a lot of referral from there ... we've been talking about, umm, groups, having cells groups, so individuals are able to build up relationships where they're able to kind of feel comfortable talking about issues, and also they can also have a time of prayer within those cell groups as well, so you can combine the practical, real issues as well as, you know, the spiritual side as well.

The wider implication is that the Forum could become a bridge between BMCs and statutory services and start important discussions about access, provision and the types of services offered to black people generally, because they are able to 'speak the language' of both parties. Through presentations, training, meet-and-greet events, the Forum could potentially develop partnerships with a range of services.

The Forum has the potential to pioneer unique programmes, which may include: demonstrating models of holistic care, providing guidance on how faith and racial issues can be addressed in the consulting room, and making a case for culturally sensitive assessment processes. The Forum will provide a range of services for churches, including clinical supervision and peer support groups for pastors. Publications and conference speaking will also form part of its remit.

Further information can be found at: www.sozotherapeuo.com

6.5.7 Church-based Mental Health Champions

I was particularly moved by participants who attended the centre, all of whom were past or present service users. I was saddened by their experiences but impressed with their resilience. They were the inspiration behind this next product.

A long-term goal is for Sozo Therapeuo to develop a training programme for individuals who wish to become church-based mental health champions. This includes a designated person(s) from a BMC who receives training on basic observation skills to recognise signs and symptoms of mental health distress, communications skills, creating partnerships with local services, signposting and referral procedures. Refresher courses will be annual and mandatory.

The next section illustrates why this product is so important, with a champion in every church it could eliminate the experiences shared below:

Kelly: I don't go church no more. When I did go, church was alright itself but it was the people, it's the bad-mine [bad-minded/ill-minded] people, When I was going before I ended up in care, I used to have, my boyfriend used to come round, I used to go to church, bring him to

church but I said, 'I just can't stand that woman X.' He said, 'Don't worry yourself just cool down.' The people were in my business, they upset my soul, I didn't like that woman, I didn't like her. The church can help but they don't want to because they know you're going [to be] like this.

Researcher: Why do you think they don't want to help?

Kelly: You only hear 'go for prayer, go for prayer' when you go for prayer, prayer can't help you, prayer can't do nothing for your head.

Diana: I would like to interject on that because, umm, my mum had mental health problems and, umm, what I found when I was a young girl, I became a carer and what I found was they [church] shun anybody who has mental health problems.

All: Yeh.

Diana: They shun them and they made them feel small, when they actually had episodes and it didn't help them at all, they believe that they were...

Nora: Possessed

Diana: ... possessed with something, exactly! Possessed, so therefore they felt the mental health was because they did wrong, and this is why it

manifest[ed] in that way. So, this is what I found and what I saw, and instead of saying, 'Oh, these children need help with a parent who is mentally ill,' they made your life worse.

Mark: That's why I didn't tell them. I don't go Catholic, but when I go to church ...

Diana: The only church I would say that I experienced help from was what I saw was X in Brixton a long time ago now. And I was so overwhelmed with the warmth and they actually help people who's in need. And I said, *my God, when I was younger I wish...* and other churches like Baptist, they would actually go round and if they didn't see somebody at church they phone, then they may even bring food for people in need. I'm not saying that everybody wants that but it's their empathy.

Researcher: In your church, do they help?

Jamie: I haven't really noticed really. The people with actual issues in the church you know how people can be, they like to be seen to be part of it. But in all honesty it's like telling that child to stop hitting that other child. No one really does anything, but they like smacking your child. They seem to do things, people want to be seen to be doing things. But genuinely they're not.

Researcher: ... what you're saying, you're human beings, intelligent people who are treated in a certain way because of how people see you.

Nora: Yeh, yeh. sometimes people think we've got a demon, that's why they tell us to get prayer.

Researcher: Those of you who have gone for prayer what was it like?

Mark: Good.

Kelly: I fell asleep [laughter].

Researcher: Should church be doing more to help people with mental health difficulties?

All Yes, yes.

Researcher: So, what do you think they should be doing?

Orphelia: Get some training, referring on, everyone should speak to each and every one and make them feel good, talking, people who want to participate should get the training.

The aim is that mental health champions will form a network for themselves across the capital. The network will provide support and information to champions, who will

be offering a much-needed resource to BMCs. The champions will be called to assist in difficult situations during church services if it is suspected someone is experiencing mental health distress. Champions will help to calm and contain a situation while a course of action is being explored. A management structure, clinical supervision and policies and procedures will all need to be put in place. This initiative seems like a good idea because of its effectiveness within BMCs.

6.5.8 Government Advisory Council

Since giving my first peer presentation at Metanoia Institute it was always the intention to make contact with a government body. The panel feedback was 'go all the way with this' and 'take it to the top.' It has hugely motivating and inspired me to create products and engage policymakers. I would like to present my findings to relevant government officials, and to explore how the products can be best utilised in the church and wider community. I would like to engage pastors and leadership teams, and I am exploring different ways to effectively achieve this; I would like government input in developing certain 'incentives' which would encourage church leaders to engage more with mental health issues. I would also like to be involved in discussions relating to policy, treatment programmes/ models and culturally appropriate therapeutic interventions. I have made contact with the Advisory Council which is part of the Government's Faith Research Centre and am awaiting a reply. Preliminary conversations have already taken place.

6.5.9 Publication

The intention is that the project to be published as a book and book chapters. In addition, publication will be sought in wider areas such as: health, theology, social care and therapy.

I plan to approach the following for publication in the first instance:

- Journal of Religion and Health;
- Journal of Spirituality in Mental Health;
- Journal of Transcultural Psychiatry;
- Journal of Religion, Spirituality and Psychiatry;
- Journal of Cross Cultural Psychology;
- The British Association for Counselling and Psychotherapy;
- Threshold;
- FutureFirst
- Crossroad (Duke University, USA);
- Association of Christian Counselling.

6.5.10 Activities

As a direct result of being a Doctoral student, I have collaborated or have been involved with the following organisations:

1. Keep the Faith Network;
2. A peer research group at my church;
3. The National Spirituality and Mental Health Forum;
4. Pentecostal Network;
5. London Centre for Spiritual Direction;
6. Churches Together England;
7. Faiths Together in Lambeth;
8. Centre for Spirituality Theology and Health;
9. BAATN (Black and Asian Therapy Network);
10. The Evangelical Alliance.

I have attended many training events, presentations and participated in a number of joint ventures. To date, I have presented my study at the Methodist Mind Matters Conference, The Black Mental Health Conference and to the Pentecostal Network.

7. Conclusion

BMCs offer many different forms of help and support to members, and have proven their ability to be sustainable and relevant in the twenty-first century. Much has changed since the Windrush generation arrived in the 1940s, introducing the first instalment of Caribbean-led Pentecostal Christianity in the UK. Today, social media and the World Wide Web have opened new channels of communication which previously did not exist. The ability to connect with more and more people from a variety of backgrounds has resulted in individuals becoming more aware of a range of issues, including mental health.

Participants in the study have an expectation that when they are in distress, appropriate help is offered by a professional, or that the church refers or signposts them to suitable services. Apart from a handful of churches, most Pentecostal churches do not provide appropriate therapeutic provision delivered by qualified professionals. With increasing cutbacks, the mental health budget is limited in the UK, and generally churches are not receiving any government assistance to support individuals suffering with mental health difficulties. The onus is therefore on churches to educate and equip themselves in order to raise their awareness on mental health issues and respond more appropriately to distressed members.

This qualitative study set out to explore the Black Majority Church and how faith and a faith community impact upon mental health and well-being. Limitations of the study may be the size and the fact that some data may not have been presented clearly enough. Also, more men in the study may have significantly impacted the outcome. Future research might include comparative studies: African and Caribbean Christians' coping strategies; Christian counselling versus mainstream counselling

(similarities, differences and impact); African and Caribbean men coping strategies within BMCs, prison and the mental health system.

The black Christian has been central to the study. Findings demonstrate that more professional and culturally sensitive resources are needed. Overwhelmingly, faith and church play positive roles in maintaining good mental health and the health benefits are undeniable. But more is expected of churches and church leaders; more awareness, more high-quality services, more support and understanding regarding issues relating to mental health. I do not claim to have resolved the problem or produced sufficient products to fill the gap in provision identified in this study. But I have come alongside, and added my contribution and products to existing services, and I am offering the Black Christian and BMCs more choice and flexibility. The findings point towards the need to create supportive and respectful church cultures in which everyone is aware that mental health – and the need to take care of it – are both universal and essential considerations, regardless of faith.

Appendices

Appendix 1: Definition of Terms

For the purpose of the study:

Black refers to people of African and African-Caribbean descent (Office of National Statistics 2006).

Christianity/Pentecostal Christianity is the religion based on the person and teachings of Jesus Christ, or its beliefs and practices (Oxford Dictionary).

Historic churches/denominations embrace all formally-organised groupings of churches that existed in Britain prior to the end of the 1800s, for example, Church of England, Anglican, Methodist (Osgood 2012).

Religious faith is defined as: a) an organised system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent (God, higher power or Ultimate Truth); and b) to foster an understanding of one's relationship and responsibility to others in living together in a community (Royal College of Psychiatry 2010).

Spirituality encompasses religion and represents anything that gives an individual life meaning, purpose and fulfilment; that which makes life worth living or meaningful to live (Mental Health Foundation 2007).

Mental health is described as the emotional and spiritual resilience which enables us to survive pain, disappointment and sadness. It is a fundamental belief in our own and others' dignity and worth (Health Education Authority 1997).

It is 'a way of describing how we feel and how we cope with our emotions ... if you're in good mental health, you can make the most of your potential, cope with the change and uncertainty in life, manage a range of feelings and emotions, play a full part in family life, employment, community and friends. It's also closely linked with our physical health' (The Mental Health Foundation).

Well-being is a state of being well, happy or prosperous (Collins Dictionary).

Mental illness/Mental Health Distress is a health condition that changes a person's thinking, feelings, or behaviour and that causes the person distress and difficulty in functioning (The National Institute of Mental Health).

Appendix 2: Origins and Development of Christianity in Africa Timeline

(BBC World Service 2009)

29, 30 or 33AD	-	Crucifixion of Jesus
100 - 2nd Century	-	Christianity comes to Alexandria from Jerusalem
180	-	12 Christians executed for beliefs in Carthage
181	-	In Carthage Perpetua refuses renounce Christianity and is sent to the lions
182	-	Emperor Diocletian launches great persecution against Christianity
4th Century	-	Collapse of Meroe kingdom
5th-7th	-	Scriptures

Century		translated into Ge'ez in Ethiopia
311	-	Donatist split
312	-	Constantine makes Christianity the official religion of the Roman Empire
333	-	Ethiopian King Ezana makes Christianity official religion
451	-	Schism (divide) with Rome on nature of God, marks the beginning of separate Coptic Church I in North Africa (taking Monophysite line, i.e. Jesus is not human as well as the

		son of God)
6th Century	-	Christianity comes to Nubia
639	-	Islam comes to North Africa, displacing Christianity on a large scale
1317	-	Nubia turns Muslim; Dongola cathedral converted to Mosque
1490	-	First missionaries come to Kongo from Portugal
1621	-	With the abdication of Emperor Susenyos, the Ethiopian Church is restored as the official church, after a period of Catholicism

1652	-	Dutch settle in the Cape; beginning of Dutch Reformed Church
1706	-	Emperor Susenyos of Ethiopia becomes Catholic; Dona Beatriz Kimpa Vita, of Kongo, is burnt at the stake, having claimed to be possessed by spirit of St Anthony
1737	-	Moravian Brethren set up in South Africa
1799	-	London Missionary Society (LMS) set up in South Africa
1804	-	Protestant mission in

		Sierra Leone
1807	-	British declare abolition of slave trade
1839	-	Pope Gregory XVI issues Papal Bull condemning slavery
1840	-	David Livingstone arrives in Africa
1865	-	Samuel Ajayi Crowther became first black Anglican Bishop in Nigeria
1868	-	White Fathers Mission Society established by Lavigerie, Archbishop of Algiers. Dedicated to mission work in

		Africa
1882	-	Nehemiah Tile's Ethiopian church founded in South Africa
1892	-	Mangena M. Mokone's Tembu National Church founded in South Africa
1886	-	Execution of Christian pages in court of Buganda by Kabaka Mwanga
1921	-	Simon Kimbangu founds EJCSK (Eglise de Jesus sur la Terre par le Prophete Simon Kimangu) or Church of Jesus on Earth through the

		Prophet Simon Kimangu
1927	-	Dimi Ya Roho (Holy Ghost Church) founded in Kenya
1939	-	1st African Catholic Bishops: Joseph Kiwanuka of Buganda, and Joseph Faye of Senegal
1960	-	Dutch Reformed Church expelled from the World Council of Churches

Appendix 3: The Rise of Pentecostalism – Christian History Timeline

(Synan 1998)

Holiness Roots

- 1867 National Holiness Association forms in Vineland, New Jersey
- 1879 Isaiah Reed forms the largest holiness association in America, the Iowa Holiness Association
- 1887 A. B. Simpson founds the Christian and Missionary Alliance to promote the Holiness 'Fourfold Gospel'
- 1895 B. H. Irwin teaches a third blessing 'baptism of Fire,' splitting the Iowa Holiness Association and forming the Iowa Fire-Baptized Holiness Association
- 1896 Schearer Schoolhouse Fire-Baptized Holiness revival experiences tongues
- 1897 Charles H. Mason and C.T. Jones form the Church of God in Christ in Lexington, Mississippi
- 1898 First congregation of the Pentecostal Holiness Church in Goldsboro, North Carolina

Pentecostal Birth

- 1901 Agnes Ozman speaks in tongues in Topeka. Charles Parham calls tongues the 'Bible evidence' for baptism in the Spirit
- 1902 First congregation of the Church of God formed at Camp Creek, North Carolina
- 1905 William Seymour accepts Pentecostal doctrine from Parham in Houston, Texas
- 1906 First General Assembly of the Church of God (Cleveland, Tenn.)
- 1906–1909 Azusa Street Revival; Pentecostalism becomes global under Seymour's leadership
- 1907 T. B. Barrett opens Pentecostal meetings in Oslo. Begins Pentecostal movements in Scandinavia, England, and Germany
- 1907 G. B. Cashwell spreads Pentecostalism in the South
- 1908 John G. Lake begins South African Apostolic Faith Mission
- 1908 Church of God (Cleveland, Tenn.) accepts Pentecostalism under A. J. Tomlinson
- 1909 Luigi Francescon and Giacomo Lombardi begin Italian Pentecostal movements in the U.S., Italy, Argentina, and Brazil
- 1909 German evangelicals condemn Pentecostals in the 'Berlin Declaration'

1909 Florence Crawford founds the Apostolic Faith Church in Portland, Oregon

Maturing Movement

- 1910 W. H. Durham begins 'Finished Work' movement in Chicago
- 1912 Maria Woodworth-Etter becomes a popular Pentecostal preacher in Dallas
- 1914 The Assemblies of God formed in Hot Springs, Arkansas
- 1916 The Oneness Movement splits the Assemblies of God
- 1919 Pentecostal Assemblies of the World incorporated
- 1923 A. J. Tomlinson forms the Church of God of Prophecy
- 1927 Aimee Semple McPherson forms International Church of the Foursquare Gospel in Los Angeles
- 1928 Mary Rumsey opens first Pentecostal missions to Korea and Japan
- 1943 American Pentecostal churches accepted as charter members of the National Association of Evangelicals
- 1945 Several mergers produce the United Pentecostal Church (Missouri)
- 1948 Healing crusades begin under William Branham and Oral Roberts

Pentecostal churches and congregations in the UK

Pentecostal churches in the West include the following:

- Apostolic Churches
- Assemblies of God
- Association of Vineyard Churches
- Church of God (Cleveland)
- Church of God in Christ
- Church of God of Prophecy
- Elim Pentecostal
- Full Gospel Baptist Church Fellowship
- Hillsong Church
- International Church of the Foursquare Gospel
- International Pentecostal Holiness Church
- New Testament Assemblies
- New Testament Church of God
- Pentecostal Assemblies of the World
- United Pentecostal Church International (UPC)

Appendix 4: Pentecostalism – Beliefs and Practices

(Howard, 1987)

Christian Beliefs

Most Pentecostals accept all mainstream Christian beliefs. (The exception is the Oneness movement, which does not accept the Trinity.)

Pentecostal churches are highly diverse, which makes it difficult to provide a definitive list of Pentecostal ideas. Nonetheless, this section covers a range of ideas and customs that are common to many Pentecostal churches.

Pentecostal churches are not 'fundamentalist', although they are sometimes described as such. Pentecostals share with Christian fundamentalists their acceptance of the status of the Bible as the inerrant word of God, but they also accept (which fundamentalists do not) the importance of the believer's direct experience of God through the work of the Holy Spirit.

The Oneness Pentecostals separated from the American Assemblies of God in 1913 over the form of words used at Baptism. They claim to go back to the earliest practice of the Apostles by baptising only in the Name of Jesus, rather than in the Name of the Father, the Son and the Holy Spirit. This practice reflects a different interpretation of Biblical verses the doctrine of the Trinity. This idea developed from a 1913 sermon by R. E. McAlister (who had founded the first Canadian Pentecostal church). McAlister showed that in the book of Acts of the Apostles and the Epistles, baptism was always carried out only in the name of Jesus Christ and not using the Trinitarian formula given in Matthew 28:19.

Therefore go and make disciples of all nations, baptising them in the name of the Father and of the Son and of the Holy Spirit.

Others joined McAlister, and after close study of the Bible they came to the conclusion that Christ contained the totality of the Godhead and that baptism in the name of Jesus Christ alone was fully effective. They noted that when Jesus used the Trinitarian formula in Matthew 28:19 he used the singular word 'name' rather than the plural 'names'.

Frank J Ewart (one of the study group members) wrote:

In the four records of administering the rite of Christian baptism in the Book of Acts, we have the name Jesus mentioned in every one of them, but the words, Father, Son, and Holy Spirit are conspicuous by their absence.

The Scriptural justification, biblical texts that supported their views included

For in Christ all the fullness of the Deity lives in bodily form. Colossians 2:9

Peter replied, 'Repent and be baptised, every one of you, in the name of Jesus Christ for the forgiveness of your sins. And you will receive the gift of the Holy Spirit.' Acts 2:38

Salvation is found in no one else, for there is no other name under heaven given to men by which we must be saved. Acts 4:12.

Sanctification

A person is sanctified when their life is dedicated to God and they are separated from their past sinful life. When a person is sanctified, they are born again to Christ through the Holy Spirit and turn away from the negative behaviours and thoughts of their old life. The word 'holiness' is also used by some churches for this concept. Whatever the word, it is something that is essential to living a Christian life:

Make every effort to live in peace with all men and to be holy; without holiness no one will see the Lord Hebrews 12:14.

Some Pentecostals teach that believers must experience a once-for-all spiritual event which leads them to '*consider [them]selves dead to sin and alive to God in Christ Jesus*' Romans 6: 10-1. The work of sanctification is carried out by the Holy Spirit. Other churches teach that believers continue to grow closer to God in a continual process of sanctification, which helps them to live a Christian life. While some Pentecostals believe that sanctification is a necessary precondition for a person to be baptised in the Spirit, others believe that baptism in the Spirit is available to anyone who sincerely gives their life to Christ. This distinction may be lost on non-specialists and it may be simpler just to say that Pentecostals believe that human beings must have come to salvation in Christ before they can receive the baptism of the Spirit.

Water Baptism

Pentecostal churches follow Scripture in practising baptism by immersion. For Pentecostals water baptism is an outward symbol of a conversion that has already occurred. It is the conversion that is essential; the water baptism is an additional element.

Child Dedication

Infant baptism is not practised in Pentecostal churches. They regard water baptism as an outward expression of an internal work of grace following an individual's choice to follow Christ. Instead, infants in Pentecostal churches are dedicated to God and blessed. This remembers the Bible stories of young children being brought to Jesus to be blessed.

Baptism in the Holy Spirit

Baptism in the Holy Spirit is the central event of Pentecostalism. The name of the movement commemorates the first baptism in the Spirit, of Jesus' disciples on the day of Pentecost.

Pentecostals believe that baptism in the Spirit is an essential part of salvation. Traditionally this is a second baptism that follows conventional water baptism, although some passages of scripture reverse this sequence.

Baptism in the Holy Spirit is an experience in which the believer gives control of themselves to the Holy Spirit (although not in a way in which they lose their own identity and autonomy). Through the experience they come to know Christ in a more intimate way and are energised with the power to witness and grow spiritually.

Spirit baptism is believed to be an action of God's grace, but one that is available only to people who put themselves forward to receive it:

And they were all filled with the Holy Spirit and spoke the word of God boldly.

Acts 4:31

The proof of having been baptised in the Spirit is speaking in tongues. Speaking in tongues is the only consistent event associated with baptism in the Spirit in the various Biblical accounts of the phenomenon.

'All of them were filled with the Holy Spirit and began to speak in other tongues.

Acts 10:45-46

Being filled with the Holy Spirit

A person who has been baptised in the Spirit is believed to have the Holy Spirit within them to empower and guide them for the rest of their life. But as well as giving a new

beginning to the believer, baptism in the Spirit gives them gifts of the Spirit which they are expected to use to bring others to faith, and generally to further Christian work.

Gifts and Ordinances

The charisma that are specifically listed as 'Gifts of the Holy Spirit' in 1 Corinthians 12:7–10, and which made their first appearance at the Pentecost celebration immediately following Christ's crucifixion, resurrection and ascension, as described in Acts 2.

The gifts of the Spirit are supernatural abilities given to believers by God. These gifts demonstrate the power of God and are used for particular purposes such as healing the sick, and generally helping the believer in their Christian ministry.

St Paul listed the gifts of the Spirit as love, prophecy, healing, wise speech, faith, miraculous and powers.

Speaking in Tongues

Speaking in tongues means speaking miraculously in a language unknown to the speaker, 'as the Spirit gives utterance' (Acts 2:4). It first happened to the disciples on the day of Pentecost.

Speaking in tongues can be either evidence of the baptism of the Holy Spirit, or a demonstration of the gift of tongues. Theological texts also use the word *glossolalia* to refer to speaking in tongues.

Miracles

Pentecostals believe that God can and does work miracles today.

Sacraments

Pentecostal churches tend to avoid anything that might be seen as sacramentalism. They do have rituals and ceremonies like communion and water baptism that other churches treat as sacraments, but Pentecostals refer to these as ceremonies or ordinances. Ordinances, like sacraments are visible representations of invisible realities.

Feet Washing

Some Pentecostal churches practice foot-washing as an ordinance of humility in their services. In doing so they follow the instructions of Jesus, who washed the feet of his disciples at the Last Supper. St John 13:14-17.

Tithing

Many Pentecostals tithe 10 per cent of their income directly to their church, which normally contributes toward church maintenance and expenses, outreach programmes and human resources.

Lifestyle

Most black-led churches expect certain standards of behaviour from their members. Alcohol, smoking, drug abuse, extra-marital sexual relations and swearing are discouraged. A large proportion of leisure time is spent with other Christians, attending services, prayer and youth meetings, choir practices, evangelistic rallies, conventions and social care activities.

Appendix 5: History of Christianity in Britain Timeline

(Lambert 2017)

c 180 AD	The first evidence of Christianity in Roman Britain.
304	St Alban is the first known Christian martyr in England.
313	The Emperor Constantine allows Christians freedom of worship.
314	Three bishops from Britain attend a conference in France.
407	The Romans leave Britain and the native people (Celts) are left to fend for themselves.
c 450	Saxons from Germany invade Eastern England. They slowly advance across the country. The Saxons are pagans and as they advance Christianity disappears from England except in the South West.
6th Century	Cut off from Rome Christians in Wales, Cornwall, Scotland and Ireland develop their own Celtic Church.
597	Missionaries are sent from Rome to preach in Kent. Eventually the people of Kent and Essex are converted.
601	Augustine becomes the first Archbishop of Canterbury.
627	The King of Northumbria (a kingdom in the north of England) is converted. Eventually the people follow.
630	Missionaries preach in East Anglia and Hampshire.
653	The king of Mercia (a kingdom in the Midlands) is converted and his people follow.
664	The king of Northumbria decides to follow the Church in Rome rather than the Celtic Church.
680	St Wilfrid begins converting Sussex, the last Saxon kingdom to become Christian.
851	The Danes invade England.
878	Alfred the Great defeats the Danes and they agree to be baptised.
Late 10th Century	There is a religious revival in England and many new monasteries are founded.
Early 13th Century	Friars arrive in England and build friaries in most towns.
1342-1416	The famous English mystic Julian of Norwich lives.
Late 14th Century	John Wycliffe denounces transubstantiation. His followers are called Lollards (meaning mutterers) because they say long prayers. They translate the Bible into English.

1438	The autobiography of a famous mystic, <i>The Book of Margery Kempe</i> is written.
1525	William Tyndale translates the New Testament into English.
1530	A Protestant named Thomas Hitton is burned at Maidstone. Thomas More calls him 'the Devil's stinking martyr'.
1534	Henry VIII makes himself head of the Church of England.
1536	William Tyndale is burned. Smaller monasteries in England are dissolved.
1539	Henry VIII closes the larger monasteries. Whitby Abbey closed 1539.
1545	Latin mass is replaced by mass in English.
1546	Anne Askew is martyred.
1549	The first Book of Common Prayer is published.
1554	Under Queen Mary the Act of Supremacy (which made the English monarch head of the Church of England) is repealed.
1553	Mary begins murdering Protestants.
1558	Mary dies and Elizabeth becomes queen.
1559	The Act of Supremacy is restored.
1570	The Pope excommunicates Queen Elizabeth
1605	The gunpowder plot, a Catholic conspiracy to blow up parliament, is discovered.
1611	The King James Bible is published.
1612	The first Baptist Church in England is formed.
1642-46	The Civil War disrupts life in England. Afterwards many people form their own independent churches separate from the Church of England.
1650	George Fox is arrested for blasphemy. He tells the judge he should 'tremble at the word of the Lord'. Afterwards Fox and his followers are called Quakers.
1661	The Corporation Act says all officials in towns must be members of the Church of England.
1662	The Act of Uniformity says all clergy must use the Book of Common Prayer.
1665	The Five Mile Act forbids non-Anglican ministers to come within 5 miles of towns with a mayor and corporation
1678	John Bunyan publishes his classic work <i>The Pilgrim's Progress</i> .

1689	The Toleration Act allows non-conformists (Protestants who do not belong to the Church of England) to have their own places of worship and their own preachers.
1701	The Act of Settlement is passed. It states that Catholics or anyone married to a Catholic cannot succeed to the throne.
1738	John Wesley is converted.
1739	George Whitefield begins preaching.
Late 18th Century	Religious enthusiasm begins to revive in England after a long period of torpor. A group of Christians called the Clapham Sect is formed. They get their name because many members live in Clapham.
1776	Holy Trinity Church in Clapham built in 1776
1829	The Catholic Emancipation Act allows Catholics to become MPs and hold public office.
1851	A survey shows only about 40 per cent of the population are at church or chapel on a given Sunday.
1865	The Salvation Army is founded.
1881	A survey shows only about 1/3 of the population attend church on a Sunday.
Early 20th Century	The Pentecostal Movement begins.
1952	C S Lewis publishes his book <i>Mere Christianity</i> .
1958	J B Phillips publishes <i>The New Testament in Modern English</i> .
1970s	House Churches are formed. The Alpha Course is invented.
1994	The Church of England ordains women priests.

In the 1st Century AD, Britain had its own set of religious icons: Pagan gods of the earth and Roman gods of the sky. Into this superstitious and violent world came a modern, fashionable cult from the east: Christianity.

We tend to associate the arrival of Christianity in Britain with the mission of Augustine in 597 AD. But in fact Christianity arrived long before then, and in the 1st Century AD, there were no organised attempts to convert the British. Christianity began when Roman artisans and traders arriving in Britain spread the story of Jesus along with stories of their Pagan deities.

Christianity was just one cult amongst many, but unlike the cults of Rome, Christianity demanded exclusive allegiance from its followers. It was this intolerance of other gods,

and its secrecy, which rattled the Roman authorities and led to repeated persecutions of Christians. Christians were forced to meet and worship in secret.

But a single religion with a single God appealed to the Roman Emperor Constantine. He saw that Christianity could be harnessed to unite his Empire and achieve military success.

From 313 AD onwards, Christian worship was tolerated within the Roman Empire.

During the 4th Century, British Christianity became more visible but it had not yet won over the hearts and minds of the population. Pagan beliefs still abounded and Christianity was a minority faith.

It looked as if Paganism might again get the better of Christianity when, after the departure of the Romans, new invaders arrived: Angles, Saxons and Jutes. Yet somehow Christianity survived on the Western edges of Britain, even during the Dark Ages. Missionary activity continued in Wales and Ireland, and in Western Scotland Saint Columba helped to bring a distinctly Irish brand of Christianity to mainland Britain.

It could be argued that it was Augustine's famous mission in 597 AD from the Pope in Rome to King Aethelbert of Kent that really set up the future course of Christianity in Britain, creating a strong alliance between Christianity and Kingship. Certainly the Venerable Bede wanted to see it this way. For Bede, a Christian England was part of God's master plan. It was Providence that meant it was the destiny of the Anglo-Saxons to become Christians, united in a single Christian nation. But how would this come about?

In the account of the Synod of Whitby in his Ecclesiastical History of the English People, Bede describes the showdown between the Irish Christianity epitomised by Saint Columba and the international Roman brand of Christianity which had been brought by Augustine.

Bede ends his Ecclesiastical History bemoaning the laziness of the Anglo-Saxons who he saw as half-hearted Christians still holding onto Pagan practices. An organised and disciplined parish life which would regulate the beliefs and behaviour of the British people was still to mature.

Christianity came at the pagan Anglo-Saxons from two directions. The Celtic Church, pushed back into Wales, Cornwall, and particularly Ireland, made inroads in the north from an early base on Lindisfarne Island. The Roman Catholic Church approached from the south, beginning with the mission of St Augustine to Aethelbert, King of Kent, in 597.

St Augustine's Mission

Aethelbert was chosen because he was married to Bertha, a Frankish Christian princess, whose support was essential. The story goes that Aethelbert, unsure of the intent of the Christian magicians, chose to greet them in the open air to ensure that they couldn't cast a spell over him. Augustine's original intent was to establish an archbishopric in London, but this ignored the political fact that London was in the realm of decidedly pagan tribes, so Canterbury, the capital of the Kentish kingdom, became the seat of the pre-eminent archbishop in England.

Saxon churches

The Celtic and Roman churches, though not incompatible, certainly enjoyed differences of opinion and practice. The Celtic church was ascetic, fervent, based on monastic life, and more loosely organised. The Roman church was more conscious of structure, discipline, and moderation. They also celebrated Easter on different days. To resolve their differences they met at the Synod of Whitby in 664, where the Roman cause triumphed.

The church was a very important force in society; the only truly national entity tying together the different Anglo-Saxon kingdoms. The early monasteries of Northumberland were vital centres of learning and the arts until they were scourged by the Viking raids of the 9th century.

The Venerable Bede

Anglo-Saxon England's most famous writer, the monk Bede, lived most of his life at the monastery of Jarrow, in Northumbria. Nearby, the monastery of Lindisfarne is famous for its' glorious illustrated bible, an 8th century masterpiece of Celtic- inspired art, which is now in the British Library.

Church education

Churches were almost the only forum for education. Under the auspices of Alfred the Great church schools were encouraged, and many Latin works were translated into

English. The higher church officials also played important secular roles; advising the king, witnessing charters, and administering estates of the church, which could be exceedingly large.

Traveling monks

Most of the early work of spreading the Christian gospel was done from monasteries. The early monks were unlike the medieval ideal with which readers of the popular Brother Cadfael mysteries by Ellis Peters are familiar. The monks of the 7th and 8th centuries were not confined to a closed monastic community, but carried the responsibility of traveling, usually on foot, throughout the surrounding countryside to preach and convert in the villages. This was especially true of monks from the Celtic monasteries. Regional, or district monasteries were established to better serve an area. These were designated 'minsters', and the term lives on in many place names, such as Warminster and Axminster.

Of the religions practiced in modern Britain, Christianity is the most long-established and widely observed. It was first brought to Britain during the days of the Roman empire. There are forty churches still in regular use, parts of which date from that period. With the departure of the legions and the Anglo-Saxon invasions of the fifth century Christianity was reduced to pockets of support in Wales, Scotland and Ireland. This situation changed with the arrival of missionaries sent by the Pope led by Augustine in 597. The next few centuries saw Christianity established throughout Britain. Augustine, meanwhile, became the first Archbishop of Canterbury, the holder of which position remains the most important figure in the Church of England.

Bishops were also established in a number of other centres, and by the end of the eleventh century a system of dioceses and parishes had been established across much of England. This system, with the creation of additional parishes and dioceses in the nineteenth century to cope with population growth and urban development, remains the basis of the structure of the Church of England. The Reformation of the sixteenth century did not disturb this structure. It did, however, fracture the Christian community in the British Isles. Links with Rome were broken and an established church owing its allegiance to the English crown replaced the medieval Church in England, Wales and Ireland. In Scotland it was replaced by the established Presbyterian Church of Scotland. Roman Catholicism survived in strength only in Ireland.

The Reformation was followed by further divisions. Conflicts over theology, church order and freedom of conscience led to a series of secessions from the Church of England in the course of the sixteenth and seventeenth centuries. These Free Churches, as they are now called, were joined in the eighteenth and nineteenth centuries by the Methodist products of the Evangelical Revival. This and the resurgence of Roman Catholicism throughout Britain in the course of the nineteenth century, largely as a result of immigration, particularly from Ireland, produced an increasingly diverse religious scene. Further immigration in the nineteenth and twentieth centuries has added to this diversity. There are now over 200 different Christian denominations in Britain.

Appendix 6: Racial Identity Model: People of Colour Racial Identity Ego Statuses
(Helms, 1995).

Conformity (Pre-encounter) status:	External self-definition that implies devaluing of own group and allegiance to White standards of merit. Probably is oblivious to socioracial groups' socio-political histories.
Dissonance (Encounter) status:	Ambivalence and confusion concerning own socioracial group commitment and ambivalent socioracial self-definition. May be ambivalent about life decisions.
Immersion/Emersion status:	Idealisation of one's socioracial group and denigration of that which is perceived as White Use of own-group external standards to self-define, and own-group commitment and loyalty is valued. May make life decisions for the benefit of the group.
Internalisation status:	Positive commitment to one's own socioracial group, internally defined racial attributes, and capacity to assess and respond objectively to members of the dominant group. Can make life decisions by assessing and integrating socio-racial group requirements and self-assessment.
Integrative Awareness status:	Capacity to value one's own collective identities as well as empathise and collaborate with members of other oppressed groups. Life decisions may be motivated by globally humanistic self-expression.

Appendix 7: Racial Identity Model: White Racial Identity Ego Statuses (Helms, 1995).

Contact status:	Satisfaction with racial status quo, obliviousness to racism and one's participation in it. If racial factors influence life decisions, they do so in a simplistic fashion.
Disintegration status:	Disorientation and anxiety provoked by unresolvable racial moral dilemmas that force one to choose between own-group loyalty and humanism. May be blocked by life situations that arouse racial dilemmas.
Reintegration status:	Idealisation of one's socioracial group, denigration of and intolerance for other groups. Racial factors may strongly influence life decisions.
Pseudo-independence status:	Intellectualised commitment to one's own social racial group and deceptive tolerance of other groups. May make life decisions to 'help' other racial groups.
Immersion/Emersion status:	Search for an understanding of the personal meaning of racism and the ways in which one benefits and a redefinition of whiteness. Life choices may incorporate racial activism.
Autonomy status:	Informed positive socioracial – group commitment, use of internal standards for self-definition, capacity to relinquish the privileges of racism. May avoid life options that require participation in racial oppression.

Appendix 8: Focus Group Research Questions, Prompts and Follow-up Questions

1. How do you support yourself through times of emotional distress?

- a) How does faith impact on your health and well-being?
- b) What role does faith play in maintaining your mental health?
- c) How do you normally approach and manage difficult life events?
- d) What is your perception of counselling and psychotherapy?
- e) What (if any) is your experience of counselling and psychotherapy?

2. What factors affect your choice when seeking help?

- a) Location, type of service (the NHS, statutory, third sector organisations), faith based, word of mouth, pastoral recommendation?
- b) What is your experience or perception of mainstream mental health services?
- c) How does this compare with the type of support offered by the black majority church?
- d) Would the ethnicity or religious background of the service provider affect your choice of therapeutic services?
- e) Have you had the experience of working with a therapist who was anti-religious?
- f) How would you cope with a therapist who does not acknowledge factors that are important to you such as faith or race?

3. What support does your church provide to individuals experiencing with mental health or emotional issues?

- a) What type of practical, (spiritual) and emotional support does your church offer?
- b) What are your thoughts about the help provided?
- c) If it were available would you undertake a counselling training course designed for Christians? Certificate level Advanced level (please tick)
- d) If you are a leader would you be interested in attending a 'counselling skills for leaders' workshop?

4. Do you think faith and faith communities play any role in maintaining mental health and well-being?

- a) How is this demonstrated in practice?
- b) How can this be measured?
- c) What is the role of faith and the faith community (church), in maintaining mental health and well-being?

5. Can you identify any positive or negative effects religious faith and faith communities may have on mental health and well-being?

- a) Do you have any experience of this?
- b) What is your experience?
- c) Have you ever experienced or witnessed this in a church setting?

Appendix 9: Ethical Approval Form

ETHICAL CONSIDERATIONS

Note: The items below cover all of those in the A/B categories of Middlesex University

	YES	NO	N/A
1. Will you describe the research procedures in advance to participants so that they are informed about what to expect? Please attach a copy of any recruitment letters and information sheet to be used?	✓		
2. Is the project based on voluntary participation?	✓		
3. Does your research involve offering inducement to participate (e.g. payment or other reward)?		✓	
4. Will you obtain written consent for participation?	✓		
5. If the research is observational, will you ask participants for their consent to being observed?			✓
6. Will you tell participants that they may withdraw from the research at any time and for any reason and inform them of how they may withdraw?	✓		
7. Will you ensure that participants are not subtly induced, either to participate initially, or to remain in the project?	✓		
8. Will you give participants the option of omitting questions from interviews or questionnaires that they do not want to answer?	✓		
9. Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	✓		
10. Have you made provision for the safe-keeping of written data or video/audio recordings?	✓		
11. Will you debrief participants at the end of their participation?	✓		

12. Have you ensured that your research is culture/belief/social system sensitive and that every precaution has been taken to ensure the dignity, respect and safety of the participants?	✓		
---	---	--	--

If you have answered 'NO' to any of the questions listed in 1 to 12 above, then please provide further details on a separate page and attach it to this application.

	YES	NO	N/A
13. Is there a realistic risk of any participant experiencing either physical or psychological distress or discomfort? If YES, what will you tell them to do if they should experience any problems (e.g. who they can contact for help.) Support will be offered a pre-determined designated person from the church and, helpline numbers and therapeutic support information will be made available.	✓		
14. Is there an existing relationship between the researcher and any of the research participants?		✓	
15. Will the project involve working with children under 16 years of age?		✓	
16. Will your project involve deliberately misleading participants in any way?		✓	
17. Will you need to obtain ethical approval from any other organisation or source? If YES, please attach letter confirming their ethical approval.		✓	
18. Are there any other ethical considerations in relation to your project that you wish to bring to the attention of the Research Ethics Committee that are not covered by the above? If YES, please describe on a separate sheet.		✓	

If you have answered 'YES' to any of the questions listed under 13 to 18 above, then please provide further details on a separate page and attach it to this application.

CANDIDATE DECLARATION

I have read the BACP and the BPS guidelines for ethical practices in research and have discussed this project with my research supervisor in the context of these guidelines. I confirm that I have also undertaken a risk assessment with my research supervisor:

Signed:.....

Print name.....Date.....
(Applicant)

RESEARCH SUPERVISOR DECLARATION

- As supervisor or principal investigator for this research study I understand that it is my responsibility to ensure that researchers/candidates under my supervision undertake a risk assessment to ensure that health and safety of themselves, participants and others is not jeopardised during the course of this study.
- I confirm that I have seen and signed a risk assessment for this research study and to the best of my knowledge appropriate action has been taken to minimise any identified risks or hazards.
- I understand that, where applicable, it is my responsibility to ensure that the study is conducted in a manner that is consistent with the World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects (see <http://www.wma.net/e/policy/b3.htm>).
- I confirm that I have reviewed all of the information submitted as part of this research ethics application.
- I agree to participate in committee's auditing procedures for research studies if requested.

Christine Stevens

Signed:

Print name..... Date: 12.3.14...

(Supervisor)

STATEMENT OF ETHICAL APPROVAL

This project has been considered by the Metanoia Research Ethics Committee and is now approved.

Signed:..... .Print name..... Date.....

(On behalf of the Metanoia Research Ethics Committee)

Please note that the Metanoia Research Committee meets twice during each academic year. Submissions between these meetings are dealt with by chair's action in consultation with one other committee member. All applications are acknowledged in writing and considered at the bi-annual Metanoia Research Committee meeting.

Appendix 10: Participant Letter of Invitation

Goldsmiths
UNIVERSITY OF LONDON

Counselling Service
St James Hall,
Block 1A,
London
SE14 6NL
Tel: 020 7919 7473
E: rburrellm@outlook.com

October 2014

Dear Pastor/Friend

I am a student at the Metanoia Institute, London W5 3XD and Middlesex University. I am exploring the black majority church (Pentecostal), and the impact that faith has upon the mental health and well-being of faith communities.

I am choosing to examine this area because I am concerned about the numbers of black people in the mental health and prison system, currently higher than any other racial group in the UK.

I am also interested in the numbers of people joining the Pentecostal church, compared to the declining numbers attending Methodist and Anglican churches. As you may be aware, Pentecostalism is the fastest growing denomination in the UK and one of the fastest growing churches worldwide.

For hundreds of years the church has played an important role in supporting its members who suffer with mental ill health, but often this is not valued or acknowledged by mental health services and the medical profession.

The study would like to invite church members to participate in a group interview, to share experiences of how faith and a faith community have impacted positively or negatively on their mental health and well-being.

Such a study has never been conducted in the UK before and, as such, provides a perfect opportunity to demonstrate the positive role that the black majority church plays in communities. It will highlight good practice and progressive initiatives, as well as improving the level of understanding between professionals and the church.

The final outcome of the study will be the development of a Counselling and Faith course, introductory and advanced levels, Counselling Skills for Leaders workshops, a radio show promoting mental health (already established on Ruach Radio), the publication of a book, journal articles and a report aimed at policy makers and government officials who influence the decisions on mental health service provision.

In order to take part in the study you must be over 18, of African or African-Caribbean decent and be attending a Pentecostal or Black majority church. If you would like to take part in the study please complete the form provided or email me to register your interest at rburrellm@outlook.com

Alternatively, if you do not wish to take part but are happy for members of your congregation to participate in the study, please forward the name and contact details of the designated person I should speak to.

Yours faithfully,

Rachel-Rose Burrell (Minister, Ruach City Church)

Researcher

Appendix 11: Participant Information Sheets

METANOIA INSTITUTE AND MIDDLESEX UNIVERSITY

PARTICIPANT INFORMATION SHEET

1. Study title:

The black majority church; exploring the impact faith has on the mental health and well being of faith communities.

(The black majority church is also referred to as Pentecostal, Evangelical or Charismatic church)

2. Invitation Paragraph

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

Thank you for reading this.

3. What is the purpose of the study?

My personal interest in this area is influenced by my experience on psychiatric wards as a trainee nurse and becoming aware of the high numbers of black people in the mental health system and the negative experiences they encounter when they engage with mental health services.

The black majority church is one of the fastest growing churches in the UK, and for many years has supported people with physical and mental illness.

The purpose of the study is to provide a unique insight into the black majority church and examine its impact on health. The study will take approximately 2-3 years to complete.

4. Why have I been chosen?

The study is aimed at individuals who are of African or African-Caribbean decent, who are Christians attending a Pentecostal or black majority church. You have identified yourself as a black Christian attending a black majority church, and registered your interest in the study via email.

5. Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

In all, ten focus groups involving up to 10 people in each and a small number of one-to-one interviews will be conducted over a seven month period.

6. What will happen to me if I take part?

The study will take approximately three years to complete. However you are only required to take part in the group and/or individual interviews at the beginning of the study. If you wish to follow the progress of the study and review the data generated from your interview, there will be opportunities for you to do so at two follow up sessions throughout the process, each meeting will take one hour. There will be a short briefing session just before and a de-briefing session after each interview, to discuss your interview experience.

Group interviews

Group interviewing or focus groups involve a small group of people brought together to discuss a particular topic. The researcher identifies the topic and creates a list of questions and poses these to the group. It is a way of generating a range of thoughts, attitudes and perspectives on a particular subject area.

The focus groups will take place at an agreed church location (approved by the Pastor) or Goldsmiths, University of London.

In order to accurately capture all responses the interview will be recorded. A research assistant will be present to make notes on the group process and assist the main researcher.

One-to-one Interviews:

This method of gathering data (information) involves the researcher identifying a subject area, creating a list of questions and inviting individual participants to meet face-to-face with the researcher to address these questions in an appropriate setting.

A semi -structured interview approach will be used which means the questions will be flexible and open ended in style, focusing on your personal experience and perceptions on the topic of discussion.

In order to accurately capture all responses the interview will be recorded.

Every attempt will be made to ensure you are comfortable and clear before the interview process begins. A high level of confidentiality and anonymity will be applied to protect your identity and privacy, any identifying features will be removed, and your name replaced with a participant identification number.

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

7. What do I have to do?

Before taking part in the interviews you will be invited to attend a pre-meeting with the researcher to go through the information sheets, discuss all aspects of the study and to provide you with the opportunity to ask questions. This will last between 45 minutes to an hour.

Once you agree to take part in the study you will be asked to sign a consent form, then a date, time and location will be agreed for the interview to take place. The group interview will last for 2 hours. The location can be an appropriate place of your choosing or at Goldsmiths, University of London.

All that is required of you is that you arrive for the interview on time, or contact the researcher if you cannot attend the interview, wish to reschedule an interview or if you wish to withdraw from the study. Attending follow up sessions to review the data is optional.

In the event of an emergency you can contact the researcher on Tel: 020 7919 7473 or for enquiries Email: rburrellm@outlook.com

Individual interviews will last one hour, group interviews will last two hours.

8. What are the possible disadvantages and risks of taking part?

Throughout the interview you may experience a level distress as you recall certain experiences and events. You can request to withdraw from the study at any time, or you can make a request for time out or, you can skip difficult questions. Details of organisations and psychotherapists where you may obtain additional support will be provided before the interview process begins.

Some participants may feel uncomfortable in a group setting especially if others are very vocal. All group participants will sign a declaration form agreeing to conduct themselves sensitively and appropriately in the focus group. The researcher is the group facilitator and part of this role involves ensuring the safety of all group participants. Clear boundaries and guidelines will be provided in writing in advance and are part of the declaration document, these boundaries will be re-stated at the start of each focus group before interviewing commences, all parties involved must agree and adhere to these guidelines.

For those participants who feel the questions provoked feelings of destabilisation in relation to their faith, they will have the opportunity to speak with a designated person from their faith community, identified in advance before the interview process commences.

All data will be stored, analysed and reported in compliance with the Data Protection legislation of the UK where the study is being conducted. Data will be stored for, no longer than 12 months after the end of the study.

9. What are the possible benefits of taking part?

It is hoped participants will enjoy taking part in the study through sharing their experiences, but this cannot be guaranteed. There is no payment for taking part in the study but your input will make a valuable contribution toward the final products of the study which include developing a Counselling and Faith training module for individuals, therapists and mental health practitioners, producing a report for government officials responsible for policy making on religious and mental health issues, developing a Counselling Skills for Leaders training course, and publishing a book.

10. Will my taking part in this study be kept confidential?

All information collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognised from it.

All data will be stored, analysed and reported in compliance with UK Data Protection legislation. The data will be stored for no longer than 12 months after the end of the study.

Confidentiality is strictly maintained within the research team directly involved in the study. Information will only be shared with a third party, such as a pastor or health professional, when the participant has agreed to this verbally, has signed a consent form and discussed with the researcher/supervisor or assigned pastor first.

Confidentiality can be breached if: the researcher would be liable to civil or criminal court procedure if the information were not disclosed. The researcher believes the participant or a third party to be in serious danger. In both cases the researcher will normally encourage the participant to pass on information to the relevant person/agency him/herself. However, if there is no indication that this has happened, or is likely to happen, or if the crisis or danger is sufficiently acute, the researcher may pass on the information directly in consultation with the research supervisor.

11. What will happen to the results of the research study?

The results of this research study will be published as part of a doctoral thesis. The results are likely to be published in October 2016, and you can obtain a copy of the published results from Metanoia Institute's library. Please be aware to protect your anonymity and privacy you will not be identified in any report or publication. The findings

of the study will also be published in academic journals and presented at conferences. In the event of this happening I will contact you to seek permission for this separately, so you have an opportunity to review such publications in advance.

12. Who has reviewed the study?

This study has been reviewed by the Metanoia Research Ethics Committee.

13. Contact for further information

For further information you can contact the researcher Rachel-Rose Burrell-Murphy at St James Hall, Block 1A, Goldsmiths, University of London SE14 6NL

Telephone: 020 7919 7473 or Email rburrellm@outlook.com

Or you can contact the Academic Supervisor Dr Christine Stevens at Metanoia Institute, 13 North Common Road, Ealing, London W5 2Q or Telephone 020 8579 2505

You will be given a copy of the information sheet and a signed consent form to keep

Thank you for reading the information sheets and agreeing to take part in this study.

Definition of Terms (breakdown)

For the purpose of the study:

Black - people of African and African-Caribbean descent (Office of National Statistics 2006).

The black majority church - a church which belongs to one of the larger denominations identified as originating in the black community e.g. New Testament Church of God or an independent church originating in the black community (with a leadership and membership/congregation largely of black people), or any church which has a leadership largely or completely of black people or any church in which the majority of the members/congregation is black, including Anglican, Roman Catholic and Baptist (Brown 1999).

Christianity - the religion based on the person and teachings of Jesus Christ, or its beliefs and practices (Oxford dictionary)

Religious faith - a) an organised system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent (God, higher power or Ultimate Truth), and b) to foster an understanding of one's relationship and responsibility to others in living together in a community (Royal College of Psychiatry 2010).

Mental health - the emotional and spiritual resilience which enables us to survive pain, disappointment and sadness. It is a fundamental belief in our own and others' dignity and worth (Health Education Authority 1997).

'a way of describing how we feel and how we cope with our emotions.... if you're in good mental health, you can make the most of your potential, cope with the change and uncertainty in life, manage a range of positive and negative emotions, play a full part in family life, employment, community and friends. It' s also closely linked (The Mental Health Foundation)

Appendix 12: Expression of Interest Form

If you are willing to participate in the doctoral study outlined above please sign below.

Signature.....

Print name.....

Date.....

Telephone number.....Email.....

Contact Address.....

.....

.....

.....

PLEASE RETURN THE SIGNED FORM TO:

**Rachel-Rose Burrell
St James Hall, Block 1A
Goldsmiths, University of London
London
SE14 6NL**

Or

Email: rburrellm@outlook.com

Appendix 13: Follow-up Letter



Counselling Service
St James Hall, Block 1A,
London
SE14 6NL
Tel: 020 7919 7473
E: rburrellm@outlook.com

October 2014

Dear Pastor/Friend

I am a doctoral student at the Metanoia Institute, London W5 3XD and Middlesex University. I would like to invite you to participate in research I am undertaking as part of my studies. The research has been approved by the Institute's Research Ethics Committee. My research project explores the black majority church and the impact faith has on the mental health and well-being of faith communities.

If you agree to participate this will involve being interviewed in a group setting of between 6-10 people. Some participants may also be asked to take part in a one-to-one interviews. Group interviews will last two hours and individual interviews one hour. Interviews will take place at Goldsmith, University of London or I can undertake the interview at a time and place that is suitable, appropriate and convenient for you. I would want to record and transcribe the interview (put thoughts speech or data into written or printed form). Before the interview stage a pre-meeting will be arranged to discuss all aspects of the study, to ensure you are clear about what to expect.

All interview data will be treated with the utmost respect and will be stored securely. However, information about the project, including interview data, will be shared with my Academic and Consultant advisors, and other appropriate staff at the Institute.

You may be concerned that other people will be able to know what you've said in the interview. I will protect you from this by removing identifying information, for example, changing your name and your exact age. You will be able to withdraw from the project at any time. The final dissertation resulting from this project will be publicly available through the Institute's library.

There is no payment for taking part in the study but your input will make a valuable contribution toward the final products of the study which include developing a Counselling and Faith training module for individuals, therapists and mental health practitioners, producing a report for government officials responsible for policy making on religious and mental health issues, developing a Counselling Skills for Leaders' training courses, and publishing a book.

I very much appreciate you registering your interest in this study and if you have any questions please contact me 020 7919 7473 or email me at rburrellm@outlook.com You can also contact my Academic Advisor Dr Christine Stevens on 020 8832 3073 if you have any questions or concerns.

I will be contacting you shortly with further information regarding pre-meeting and interview dates.

Thank you

Rachel-Rose Burrell
Researcher

Appendix 14: Focus Group Booking Form

Research: The Black majority church; exploring how faith impacts the health and well-being of faith communities

Dear Participant

Thank you for agreeing to take part in the above study by attending a group interview.

The group interviews will last for two hours and will be held at St James Hall, Block 1A, Goldsmiths, University of London SE14 6NL.

You will need to arrive 20 minutes before the start of the interview to discuss the information sheets, sign the consent form and raise any questions or queries.

Please choose as many dates from the options below. You will only be required to attend **ONE** group interview.

I am available to attend a group interview session on:

Wednesday 22 October 6 - 8pm ☒

Wednesday 29 October 6 - 8pm ☐

Wednesday 5 November 6 - 8pm ☐

Wednesday 12 November 6 - 8pm ☐

Wednesday 19 November 6 - 8pm ☐

Wednesday 26 November 6 - 8pm ☐

Wednesday 3 December 6 - 8pm ☐

Wednesday 10 December 6 - 8pm ☐

Friday 24 October 4 - 6pm ☐ 6 - 8pm ☐

Friday 31 October 4 - 6pm ☐ 6 - 8pm ☐

Friday 7 November 4 - 6pm ☐ 6 - 8pm ☐

Friday 14 November 4 - 6pm ☐ 6 - 8pm ☐

Friday 21 November 4 - 6pm ☐ 6 - 8pm ☐

Friday 28 November 4 - 6pm ☐ 6 - 8pm ☐

Friday 5 December 4 - 6pm ☐ 6 - 8pm ☐

Saturdays are available on request, at a suitable church/location 12 -2pm. If you would prefer a Saturday session please specify a date_____

Please return this completed form to Rachel-Rose Burrell-Murphy St James Hall, Block 1A, Goldsmiths, University of London SE14 6NL or email to rburrellm@outlook.com

If you have any questions or queries please telephone 020 7919 7473.

You will receive confirmation of your interview date shortly.

Thank you

Rachel-Rose Burrell

October 2014

Appendix 15: Consent Form

CONSENT FORM

Participant Identification Number: _____

Title of Project: The black majority church; exploring the impact faith has on the mental health and well-being of faith communities

Name of Researcher: Rachel-Rose Burrell

Please initial

1. I confirm that I have read and understand the information sheet _____
datedfor the above study and have had the
opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to _____
withdraw at any time, without giving any reason. If I choose to withdraw,
I can decide what happens to any data I have provided.

3. I understand that my interview will be taped and subsequently _____
transcribed.

4. I agree to take part in the above study. _____

5. I agree that this form that bears my name and signature _____
may be seen by a designated auditor.

_____	_____	_____
Name of participant	Date	Signature

_____	_____	_____
Name of person taking consent (if different from researcher)	Date	Signature

_____	_____	_____
Researcher	Date	Signature

1 copy for participant: 1 copy for researcher

Appendix 16: Participants' Personal Information Sheet

Participant Personal Information Sheet

PRIVATE AND CONFIDENTIAL

Please do not write your name on the form Participant ID No. _____

Date _____

Please state your:

1. Age.....

2. Gender.....

3. Ethnicity/Racial background.....

4. Occupation.....

5. Relationship Status.....

6. How long have you been a practicing Christian?.....

7. Do you consider yourself to have or ever had a mental health problem?

Y/N (please circle)

Today are you participating in a:

1. Group Interview Y/N (please circle)

2. Face-to-face Interview Y/N

Appendix 17: Focus Group Script

INTRODUCTION

House keeping

- ☐ Toilets
- ☐ Fire
- ☐ Room temperature

Ground Rules

1. Relax and enjoy
2. Talk freely
3. Everyone is encouraged to participate
4. Please be respectful
5. Please accept difference and the right for everyone to have their own opinion
6. Mobile phones

Focus Group Introductory Statement

- ☐ Welcome, thank you for taking the time to join the discussion today about

The black majority church; the impact faith has on the mental health and well-being of faith communities.

- ☐ My name is ... and I will be the moderator for today's group discussion
- ☐ Assisting me is....
- ☐ The purpose of today's discussion is to get information from you about how faith impacts mental health and well being.
- ☐ I will be asking 5 questions
- ☐ There are no right or wrong answers to the questions I am about to ask
- ☐ We expect that you will have differing points of view
- ☐ Please feel free to share your points of view even if it differs from what others have said
- ☐ If you want to follow upon something that someone has said, you want to agree, disagree, give an example, feel free to do that.
- ☐ Don't feel you have to respond to me all the time
- ☐ Feel free to have a conversation with each other about these questions
- ☐ I am here to ask questions, listen and make sure everyone has a chance to share.

- ☐ We're interested in hearing from each of you, so if you're talking a lot, I may ask you to give others a chance, and if you're not saying much, I may call on you to contribute a little more.
- ☐ We just want to be sure we hear from all of you.
- ☐ Feel free to get up and get some refreshments
- ☐ We will both be taking notes to help us remember what is said
- ☐ We are also tape recording the session because we don't want to miss any of your comments.
- ☐ We have names in front of us here today but no names will be included in any reports.

CLOSING

- ☐ Final questions - Have we missed anything?
- ☐ 2-3 minute summary

Appendix 18: Participants' Demographic Information

Age

Age Range	24 and under	25-34	35-44	45-54	55-64	65-74	75 and over	Declined
No. of Participants	0	4	5	23	8	4	2	2

Gender

Gender	Male	Female	Declined
No. of Participants	11	45	0

Racial Identity

Ethnicity	Africans	Caribbeans	Black British	Other	Declined
No. of Participants	13	32	4	3	2

Racial Identity – Self defined	No. of Participants
Black Caribbean	14
Black African-Caribbean	1
African-Caribbean	8
Caribbean	2
Jamaican	3

African	2
Black African	2
African Black British	1
Black	1
Black British	4
Black British Caribbean	5
Black West Indian British	1

Appendix 18: Standard Occupation Classification (The SOC Hierarchy)
Categories based on Office for National Statistics

Occupation Major Groups	No. of Participants
1.Managers, directors and senior officials	8
2.Professional occupations (e.g. Health professional, teaching)	9
3. Associate professional and technical occupations (e.g. science, engineers)	5
4. Administrative and secretarial occupations	1
5. Skilled trades occupations (e.g. electrician, construction)	11

6. Caring, leisure and other service occupations	6
7. Sales and customer service occupations	
8. Process, plant and machine operatives	
9. Elementary occupations (e.g. trade, administration)	5
10. Other	8
11. Unemployed	3
12. Declined	7

Marital Status

Marital Status	Single	Married	Separated	Divorced	Partnered	Widower	Declined
No. of Participants	25	15	1	2	1	1	8

Appendix 18: Participants' Demographic Information

How Long been a Christian?

How long a Christian?	Less than 5 years	6-10 years	11-20 years	21-30 years	31-40 years	More than 40 years	Declined
No. of Participants	2	6	10	5	8	10	3

Have/Have had Mental Health Difficulties

	No. of Participants Yes	No. of Participants No	Declined
Mental Health Difficulties	22	32	12
Male	3	2	7
Female	7	18	18

Type of Church

Type of BMC Self-defined	No. of Participants
Pentecostal	22
Charismatic	3

Evangelical	4
Sabbatarian	3
Historic	2
Catholic	10
African -led	2
Independent	6
Other	2
Declined	0

Appendix 19: Participants Transcript Checking Instructions

Important Research Document Attached

Dear Research Group Participant
Happy New Year.

I am writing to inform you that the transcription process is finally complete, despite several unforeseen challenges which caused delay to the project. I would like to invite you to read through the attached document in order to confirm it is a true reflection of what was said during the interview group, and to identify any areas which you feel are inaccurate or unclear, and to give you the opportunity to replace these with alternative words, sentences or phrases.

The attached document is a written account, taken directly from the recording of the interview group you took part in between the period 2014-2015. I appreciate a considerable amount of time has passed and you are not expected to remember everything you said. At this stage the purpose is simply to identify any portion of the text that appears incorrect or unclear. Names have been replaced with a participant number e.g. P1, P2, and times are included purely for administrative purposes. Question marks e.g. ????, throughout the document are an indication that the word or words on the recording are either inaudible or hard to understand. So, if you recognise yourself as the speaker and can clarify or provide a word or phrase, please do so, you can also withdraw any comment you made.

In order to make an adjustment or add clarity, please send me an email and include the page number, participant number, the original text (ie the word or words to be changed), time if applicable, and the change you would like to make.

The deadline for responses is **February 3rd 2017**. If I do not hear from you by this date, I will assume you do not wish to make any adjustments to the text, and I will therefore proceed to the next stage of data analysis. I will contact you again with a summary of the results once the analysis is complete.

Thank you again for supporting this study and I look forward to hearing from you,

Best wishes

Rachel-Rose

Researcher

Appendix 20: Original Code/Nodes Focus Groups

<p>Black Issues</p> <ul style="list-style-type: none"> Black culture Black history BMC Cultural differences Differences between denomination Gender differences Social differences Church Role in MH Christian Practices Mass daily Praise and worship Prayer Preaching Faith community role maintaining mh How church affects community How church maintains mental health Relieves and suspends Church forget problems Forget troubles Refreshing The People Inclusive Relationship Sharing experiences testimonies The Place Church like food Church safe place Church liberating Place of healing 	<p>Counselling Psychotherapy</p> <ul style="list-style-type: none"> Accessibility availability of counselling Adequate facilities Church being equipped Therapist Therapy <p>Factors Affecting Choice</p> <ul style="list-style-type: none"> church v secular counselling service Accountability Boundaries re church counselling Confession like therapy Confidentiality creating safety in the church Ethics church counselling Trust <p>Helper Characteristics</p> <ul style="list-style-type: none"> Colour Maturity Personality Qualities of helper <p>Influences on choice</p> <ul style="list-style-type: none"> What affects choice of help <p>Personal Preference</p> <ul style="list-style-type: none"> Difficulty talking Instinct
--	---

<p> Reluctant to access help Researching the therapist Unable to ask for help Unable to take care of self Uncomfortable questions Professional Services Avoiding external services Church anti counselling No therapy Secular services The mental health system and black people Upbringing Faith's role maintaining mental health Faith Fact v emotions It's real Knowing Faiths Role MH Comfort Forgiveness Gain Strength Hope Inner peace love Strength How faith maintains mental health Health and Wellbeing Healing Process mental v physical health Leadership team Leadership not equipped Leader acknowledge limits </p>	<p> Pastor important Pastor leadership style Pastor too busy Let down Mistreated by church Re traumatising people treated unfairly in church No church Pastor Last resort Restrictions in church Interpretation of scripture Partnership working Combination approach Online Christian resources Referral process Positive and Negative impact of faith community Positive and negative impact of faith community Christians with mental health difficulties Discrimination Excluded Ignored Stigma Hospitalised Lack of faith </p>
--	--

Leadership Leader's qualifications	
---------------------------------------	--

<p>Lack of support</p> <p>Medication</p> <p>Suicidal thoughts, plan</p> <p>Vulnerable</p> <p>Feeling lost</p> <p>Isolated</p> <p>Won't disclose MH</p> <p>Church response to distress, illness, mental health</p> <p>Cliques</p> <p>Hostile</p> <p>Not genuine</p> <p>Negative church on mental health</p> <p>Lack of awareness</p> <p>understanding</p> <p>Positive and negative impact of faith community</p> <p>Positive impact church on mental health:</p> <p>Not judged</p> <p>Social</p> <p>Source of help and support</p> <p>The atmosphere</p> <p>Positive and negative impact of faith on mental health</p> <p>Negative Faith on mental health:</p> <p>Bad things</p> <p>How God allows?</p> <p>My faith v my desires</p> <p>Unrealistic expectations</p> <p>Wallowing</p>	<p>God</p> <p>Dream or vision</p> <p>God is Counsellor</p> <p>Going to God last resort</p> <p>Relationship with God</p> <p>Religious activities rituals</p> <p>Dancing</p> <p>Music</p> <p>Reading the bible</p> <p>Repeating prophesies</p> <p>Repeating scriptures</p> <p>The Bible</p> <p>Rituals</p> <p>Singing</p> <p>Self-care</p> <p>Coping Strategies</p> <p>coping prior to Christianity</p> <p>Friends and family support</p> <p>Helping others</p> <p>Journaling</p> <p>Mindfulness</p> <p>Stressful events</p> <p>Talk to non-therapist</p> <p>Too busy for MH</p> <p>Emotional Response</p> <p>Challenges</p> <p>Reaction to distress</p> <p>Attitude to life</p> <p>Interpretation of problems</p> <p>Learning from previous exp</p> <p>Life experience, advice,</p>
--	--

<p>Positive faith on mental health</p> <p>Faith outcome:</p> <p>Calm</p> <p>Me time</p> <p>Being alone</p> <p>Gardening</p> <p>Powerful</p> <p>Release of emotion</p> <p>Crying</p> <p>emotional release</p> <p>Meditate</p> <p>Relief</p>	<p>knowledge</p> <p>Personal accounts</p> <p>Positive affirmation</p> <p>Previous experience</p>
--	--

<p>Self-care</p> <p>Men and Worship</p> <p>Reaction to distress</p> <p>Reflection</p> <p>Writing to God</p> <p>the enemy</p> <p>Reaction to Distress (2)</p> <p>Spiritualising problems</p> <p>Deliverance</p> <p>Demon possession</p> <p>What support church provides</p> <p>Church activities</p> <p>BMCs small and large</p> <p>Children and young people</p> <p>Men</p> <p>Newcomers</p> <p>Older women</p> <p>Progress in the church</p>	<p>Church Culture</p> <p>Church infra structure</p> <p>Church Insular</p> <p>Church lack of knowledge</p> <p>Church outdated</p> <p>Practical Christianity</p> <p>Being listened to, talking</p> <p>Being noticed and missed</p> <p>Personal responsibility</p> <p>Responsibly for each other</p> <p>Recommendations</p> <p>Being open about mental health</p> <p>Care package</p> <p>Church model of support</p> <p>Church What helps</p> <p>Good practice</p> <p>Professionalism in church</p> <p>Professionals in the church</p> <p>Publicising church support</p> <p>Training</p> <p>Holistic</p>
---	---

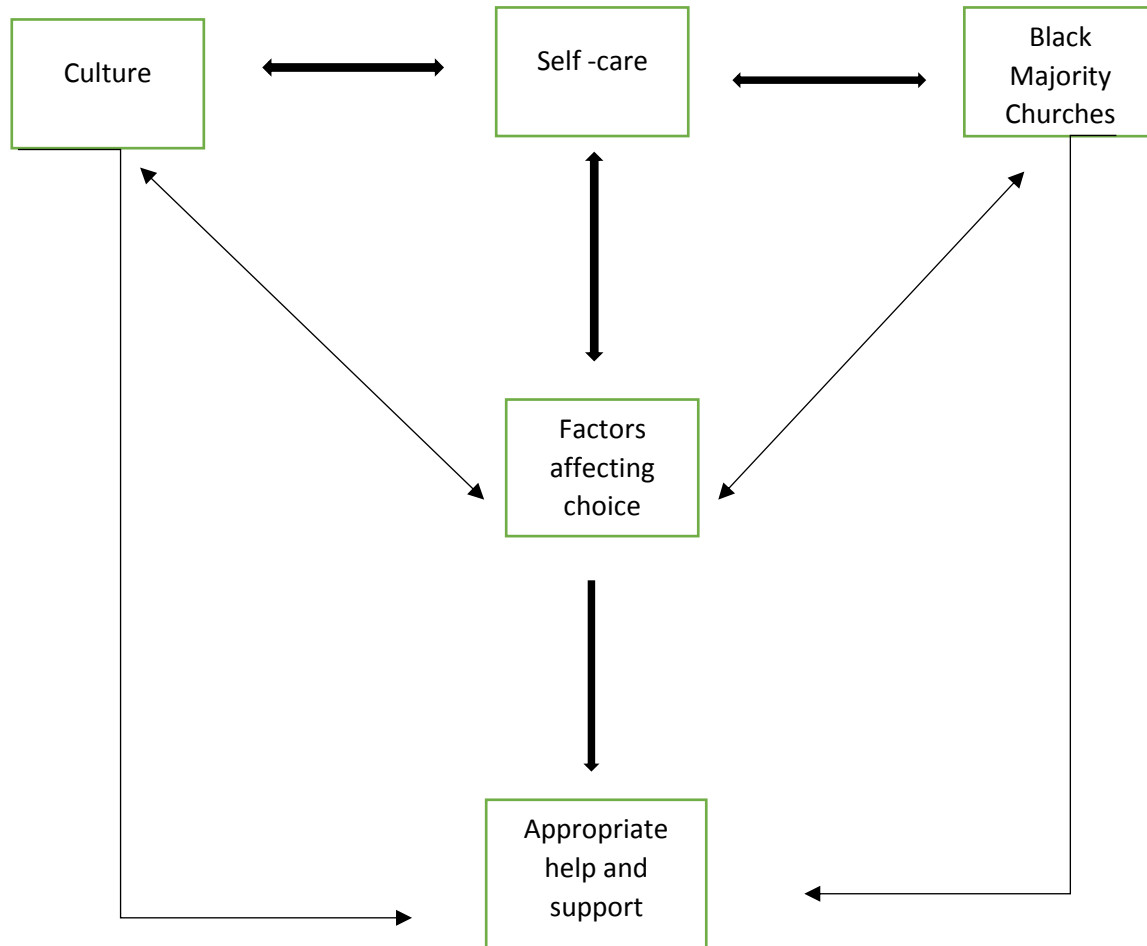
Appendix 21: Original Codes/Nodes Individual Interviews

<p>Q1 What is MH? Emotional psychological thought processes Health and well-being?</p> <p>Q2How faith and church impact mental health? Q2 a) faith Faith negative Faith Positive and Negative</p> <p>Faith positive belief in and apply word of God deal with life Calmness Can cope Clarity Coping Faith empowers Faith God coping strategy Focus? God not alone Gratitude focus on positive Hope music change thoughts and focus Music singing PandW Positive impact Reassurance</p>	<p>Q2 b) church church neg impact on mental health Believer but no church Church controlling Church lack of knowledge and understanding Church limitations Deliverance Disrespected Disempowering Inadequate counselling and Holistic care Increases stress Insufficient black senior professionals Insufficient black-centred mental health resources</p> <p>Negative effect? Worsens situation</p>	<p>Church positive Acceptance and belonging Atmosphere Avoid isolation Church wide age range Church safe and supportive environment Church glad to be a part of Collective group activities Worship, singing, prayer Community Confession like therapy Prayer like talking to therapist Prayer, be still Preaching Feel good, boost, uplifting Ideal qualities and atmosphere? Inspiration? Music change thoughts and focus Music singing PandW Positive impact Purpose Realise potential Relationships? Spiritual and social benefits The Bible Wisdom</p>
---	---	--

<p>Recognise God's power</p> <p>Release emotion</p> <p>Relief and solace</p> <p>Resilience</p> <p>The Bible</p> <p>Turn to God in difficult times</p> <p>Q3 Why black people go to church?</p> <p>Generational</p> <p>Heritage</p> <p>Identity</p> <p>Worldview v church view</p> <p>Self- perception</p> <p>Purpose</p> <p>Provide family stability</p> <p>Q4 Why black people in the mental health System</p> <p>BI MH misunderstood</p> <p>Black culture</p> <p>Black History</p> <p>Black men</p> <p>Breakdown in family unit</p> <p>Breakdown in relationship</p> <p>Cultural diffs</p> <p>Cutbacks</p> <p>Isolation</p> <p>Keep feelings in</p> <p>Lack of support for family breakdown</p> <p>Lack of teaching, education, training</p> <p>Mental health stress with no</p>	<p>Stigma</p> <p>Unable to cope with life</p> <p>Social challenges</p> <p>Q5 what church support helpful?</p> <p>Advice</p> <p>Advocacy</p> <p>Appropriate Pastoral support</p> <p>Become more open</p> <p>Befriending groups</p> <p>Church new outlook</p> <p>Church openness to mental health</p> <p>Church have adequate resources</p> <p>Church meet needs and activities</p> <p>Groups</p> <p>Information</p> <p>Less fear</p> <p>Less gossiping</p> <p>Mutual support</p> <p>Non-Judgemental</p> <p>Patience</p> <p>Understanding</p> <p>Personal experience</p> <p>Practical support</p> <p>Spiritual support?</p> <p>Signposting</p> <p>Someone to talk to</p> <p>Therapy</p>	<p>Q6 Professional helper ignore faith, race etc</p> <p>Avoid, refuse to work with prof</p> <p>Provide diff perspective</p> <p>Unable to trust?</p> <p>Unsafe</p> <p>Unsupportive</p> <p>Waste of time</p> <p>Q7 Group experience what was it like?</p> <p>Group participant inspired to research</p> <p>Positive or negative group experience</p>
--	--	--

support MH system lack of change MH system no knowledge black culture faith etc MH system white middle class managers Mind is complex -unknowns Misdiagnosis Misinterpretation and judgment Not accessing services or delay Misunderstood Professionals lack of understanding Racism and discrimination Racism discrimination Stereotyped/Stereotyping		
---	--	--

Appendix 22: Preliminary Map of Overarching Themes



Appendix 23: Table of Combined Themes

Combined Main Themes - Focus Groups and Individual Interviews

<u>Overarching Themes Focus Groups</u>		
1.Culture	2. Appropriate help and support	3. BMC

<u>Main Themes</u>		
What is mental health?		
Focus group reflections		
Black issues	Self -care	Church Identity
	Factors affecting choice	Leadership
Health and Wellbeing		Spiritualising problem
Positive and negative impact of church	Counselling and Psychotherapy	What support churches provide?
Positive and negative impact of faith	Partnership Working	Church role in maintaining mental health
What are effects of a professional helper who ignores faith or race?		
Why do so many black people go to church?		Faith's role in maintaining mental health
Why are so many black people in the mental health system?		Let down

Illustration of merged focus group and individual interviews main themes (individual interview themes in bold)

Appendix 24: Participants' Descriptions of Barriers to Seeking Help

Internal – in the church	External - mental health and therapeutic services
<ul style="list-style-type: none"> • Lack of confidentiality • Lack of skill, expertise on mental ill health • Unqualified • Confidentiality concerns • Spiritualise natural/medical problems • Leaders unavailable/inaccessible • Church unfriendly and unwelcoming • Not being listened to • Ignorance 	<ul style="list-style-type: none"> • Suspicious of statutory services • Negative experience/perception of services • Emphasis on medication • Pathologise problems and expressions of faith • Lack of understanding/cultural sensitivity • Unable to speak freely about faith • Racism, discrimination • Not being listened to • Arrogance

Appendix 25: Mental Health Awareness Training Programme

Sozo Therapeuo Mental Health Awareness Training for Church Leaders

Croydon Park Hotel

July 23rd 2016

Agenda

Time	Activity
9.30am	Registration, Tea/Coffee and Ice Breaker
10.00	Welcome, Ground Rules, House Keeping Introductions, Desired Outcome What is Mental Health?
Part 1	The many ways mental health issues manifest in people's lives
10.05	Common Mental Health Problems and Stigma
	Possible Causes of Mental Health
	Mental Health and The Church
10.45	Check in, Burning Questions, Thoughts.
10.50 -11.00	B R E A K
Part 2	Create a church culture that supports people with mental health problems
11.00	Looking After Yourself
	Five Ways to Wellbeing
	Looking Out for Others
Part 3	Access support for leaders and members of the congregation
11-15	When to Refer, When to Involve Others
	Where to Get Help, Self Help
	Questions, Thoughts, Check -in
11.25	Introduction of Case Studies/Small Group Discussions
11.30	B R E A K
11.35	Group Discussion – Case studies
11.55	Feedback into Larger Group
12.05pm	Panel - Questions and Answers
12.25	Mindfulness, Summary, Evaluations, Close
12.30-1pm	L U N C H

© sozo therapeuo

Appendix 26: Feedback - Mental Health Awareness Training

Sozo Therapeuo

Mental Awareness Training for Church Leaders

Feedback from 23rd July 2016

21 delegates in total attended

9 Delegates (who registered) did not attend

24 In total originally registered via Event Brite

The following summary is based on the 17 evaluation forms which were returned at the end of the training.

Criteria	Strongly Disagree	Disagree	Don't know	Agree	Strongly Agree	No Comment
The training was relevant	-	-	1	5	11	
Materials provided were helpful				10	7	
Length of training was sufficient		1		9	6	1
Content was well organised				6	10	1
Questions were encouraged		1		8	8	
Instructions were clear and understandable				7	10	
Training met my expectation		1		6	10	
The presenters were knowledgeable about the training topic				7	10	
The presentation was effective				7	10	
The meeting room and facilities were adequate and comfortable		1 Facilities good make Room slightly larger	1	6	9	

1. What was the main reason for attending this training sessions?

- to get more knowledge and understanding about myself
- know about Sozo Therapeuo
- Learn more awareness
- Reason is to gain a wider and better understanding of mental health
- To have more knowledge about mental health in churches
- Increased awareness
- Broaden my understanding of mental health and be equipped
- To be aware of this in the congregation
- To gain more awareness of mental health and especially how it impacts the church
- To be more informed about mental health
- To increase my knowledge of mental health
- To gain awareness
- To get to know more about mental health
- Information on mental health awareness
- Know more to deal with mental awareness
- Need to know how to deal with Health issue

2. What did you like most about this training?

- the presenter were very good
- the openness of the facilitators, very realistic and practical
- case studies
- The information given/points covered
- I enjoyed the entire training, especially the spectrum demonstration
- The presentations
- Case studies
- Case Study
- Informative
- Presentation/Knowledge/everything really
- The content was interesting – knowing more about myself
- It was invaluable – changed my own thoughts
- Knowledge
- It covered all areas of mental health
- Examples, scenarios and group work
- Case studies

3. What aspects of the training could be improved?

- Longer time for group work

- It was well organised and not too lengthy
- Making it longer to accommodate questions
- Well presented
- Encourage people from personal experience even when they may allow for it?
- None – it was most enjoyable and interesting
- Address gender issues
- NONE – maybe more time
- Should be all day training
- More time

4. What did you learn today that you anticipate using for yourself and/or in your church?

- Everything
- Will feedback everything to my Pastor as previous agreed with him
- Help with real life situations
- Quite a lot
- To be more open and understanding to our congregants
- Everything
- Dealing with emotional injuries
- Identify! How to deal with people who is in need in and outside of the church use this to evangelise
- Helping other to overcome mental health problems
- Take care of ME more
- We all suffer from some sort of mental health – don't be afraid to ask for help
- Improve my listening skills
- Give people more time
- It will help me to be more aware of mental health and you have to start with me
- To reflect on myself – know I am able to go there with another
- Life examples, spotting early signs and symptoms
- How to learn to listen more

5. What additional training would you like to have in the future?

- Race and trauma
 - Uncertain
 - Sozo training
 - Continuous training and development
 - Counseling Ministry Team
- More in-depth training would be good with scenarios

- Whatever is available on going
- Depression/Anxiety
- Personal counselling
- More on helping pastor

6. Would you recommend this training to others?

- Yes
- Yes, most definitely, not just for people of color
- Yes
- Yes definitely
- Certainly will
- Yes
- Yes
- Yes
- Yes
- Yes
- Yes
- Yes
- Yes
- Yes definitely
- Yes
- Yes
- Oh Yes

7. General comments:

- I enjoyed it
- Room to warm – No a/c
- Thank You - Great Class!
- Great course of training, much appreciated – Thank you
- Very interesting, relevant and helpful
- The training was well informative
- Heard via Email
- Thank You
- Heard about this in MH programme from email
- Excellent, I thoroughly enjoyed – would be good to have an all day seminar
- Nothing pressing
- Good course

- Thank you
- Hear via from email from BAATAN
- Very Good
- My church could be bless by this

I give permission for my quotes to be used anonymously	
Yes	11
No	2
No Comment	5

Appendix 27: Counselling Skills for Church Leaders Training Programme

Sozo Therapeuo Introductory Counselling Skills for Church Leaders

24th June 2017 at The Gaumont State Theatre

Programme

Time	Activity
09.30	Registration, Tea/Coffee and Ice Breaker
10.00 Rachel-Rose Burrell (Host)	<ul style="list-style-type: none"> ▪ Welcome ▪ What is Sozo Therapeuo? ▪ Ground Rules/ House-keeping introductions ▪ Desired outcome ▪ What are Counselling Skills?
Part 1	Key Counselling Skills
10.10 Claudine	<ul style="list-style-type: none"> ▪ Core Conditions of Counselling
10.20 RRose	<ul style="list-style-type: none"> ▪ Key Counselling Skills
10.55	<ul style="list-style-type: none"> ▪ Check in, Burning Questions, Thoughts.
11 -11.15	B R E A K
Part 2	Practical Application
11.15 Yolanda	<ul style="list-style-type: none"> ▪ Creating a Conducive Environment for Counselling
11.25 Errol	<ul style="list-style-type: none"> ▪ Barriers to Good Communication
11.40	<ul style="list-style-type: none"> ▪ Questions, comments
11.45 – 12pm	B R E A K
Part 3	Skills in Action
12pm-12.30 Rachel-Rose	<ul style="list-style-type: none"> ▪ Introduction of Role Plays, Case Studies, Practice Sessions in small groups of 3
12.30	<ul style="list-style-type: none"> ▪ Feedback into Larger Group
12.40	<ul style="list-style-type: none"> ▪ Panel Questions and Answers
12.50	<ul style="list-style-type: none"> ▪ Summary ▪ Where to get help/Self help ▪ Evaluations, Close
13.00	L U N C H

© sozo therapeuo

Appendix 28: Feedback - Counselling Skills Training

Sozo Therapeuo

Introduction to Counselling Skills for Pastors and Church Leaders

Feedback from 24th June 2017

23 delegates attended

9 Delegates (who registered) did not attend

24 registered via Event Brite

The following summary is based on the 21 evaluation forms which were returned at the end of the training.

Criteria	Strongly Disagree	Disagree	Don't know	Agree	Strongly Agree	No Comment
The training was relevant				5	16	
Materials provided were helpful			1	4	16	
Length of training was sufficient		2	2	7	10	
Content was well organised			1	7	13	
Questions were encouraged				7	18	2
Instructions were clear and understandable				7	14	
Training met my expectation		1		5	15	
The presenters were knowledgeable about the training topic				5	16	
The presentation was effective				7	10	
The meeting room and facilities were adequate and comfortable			1	5	15	

1.What was the main reason for attending this training sessions?

- Effective communications with family/friends
- To obtain more knowledge/information to help our church

- To gain information/personal interest
- Considered my role and some of the people I deal with
- To learn about how to support/encourage people within community
- Help with counselling others
- I thought the counselling was on black mental health
- Recommendation from a friend
- Develop my skills and awareness
- Identified as part of my CPD

2. What did you like most about this training?

- The content/learning
- Case studies as it opportunity to share/network x 2
- Very real/good examples
- Roles plays and interaction x 4
- Insight into mental health counselling
- Very informative and space x 2
- Everything was important and friendliness of every one x 2
- How each topic was explained clearly
- The delivery
- The delicate examples given

1. What aspects of the training could be improved?

- Less time on knowledge giving and more on how to apply and advice/presenting
- poor/unhealthy mental health through counselling
- Time x 2
- More time to discuss
- Opportunity to discuss particular skills
- None – All well organised
- Nothing
- More time for each topic
- Timing...Maybe longer time allocation
- The helper roles
- QandA and Panel time x 2

- More networking opportunities with others
- Suggested reading notes

2. What did you learn today that you anticipate using for yourself and/or in your church?

- Active listening x 2
- Listen more not to always give advice X 3
- Checking self-awareness
- Lots of things
- Everything x 2
- Responding to client, ways of feedback x 2
- Ways in which you ask questions
- Relevant information given which I will be using
- Self-awareness. listen not to be judgemental X 2

3. What additional training would you like to have in the future?

- Self-awareness and personal awareness
- Mental health in the black community
- An official training
- Looking into counselling further
- Counselling and deliverance
- Deeper information with regards to this topic
- Longer time..the whole day
- Next level to introduction
- Any relevant information regarding ministry
- What to do when someone is suicidal and know about child abuse practice
- Exploring counselling on a deeper level
- Mental training and dealing with spiritual issues
- More development in counselling

4. Would you recommend this training to others?

- Yes x 11
- Definitely X 3
- Absolutely Yes!!!

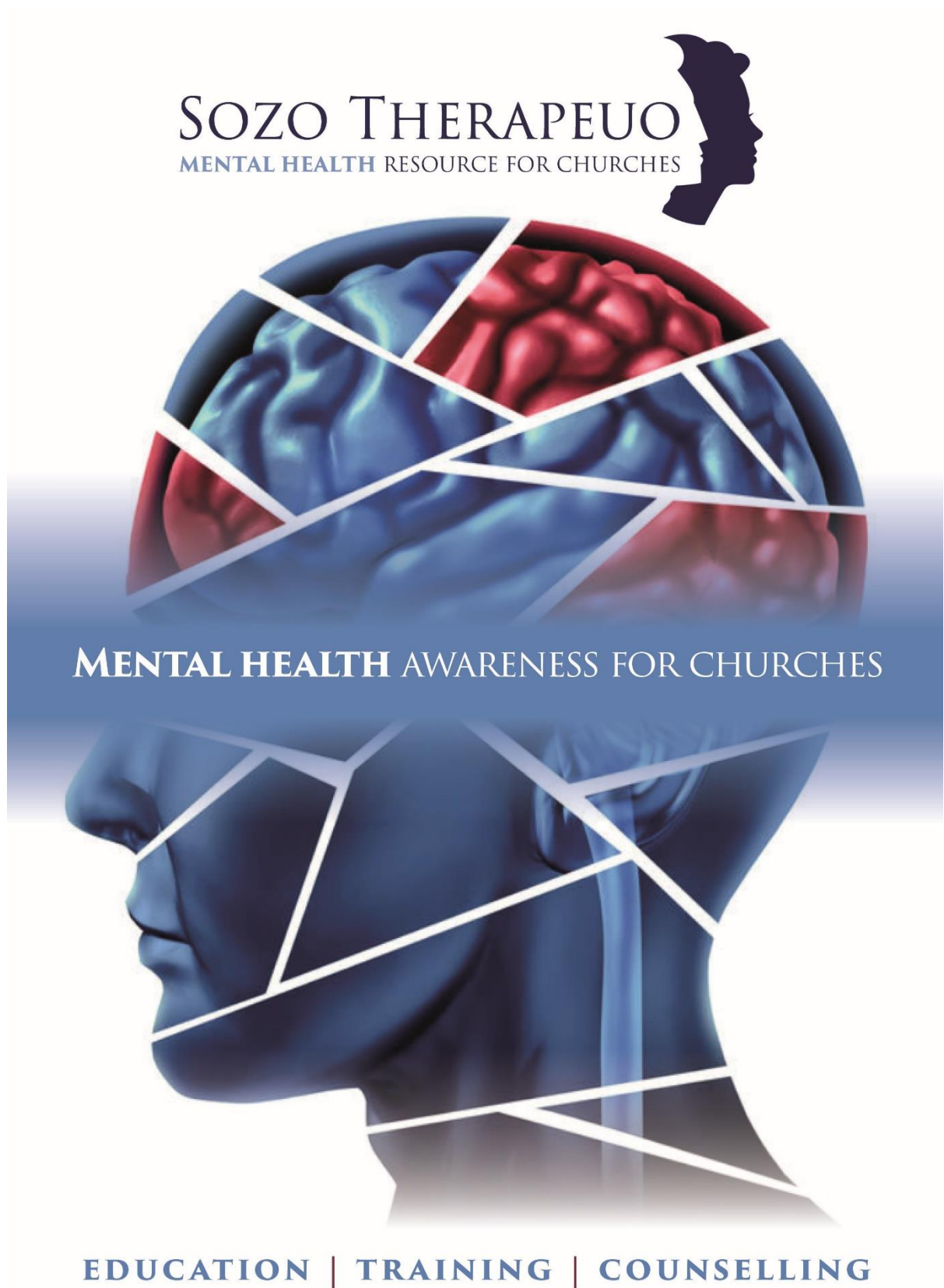
- Yes very much so x 2

5. General comments:

- Great course, loved it learnt a lot, presenters good knowledge, warm friendly
- Thank You, informative session which reflected on developing and utilising counseling skills
- Informative
- A very enjoyable, high standard course
- Excellent...more please
- Insightful
- Course was excellent, enjoyed everything that was taught
- Overall this training was very good and it opened my eyes to things that I did not know
- Very good training, well presented and socially very good in meeting others..Thank you very much for today well appreciated and enlightening
- Very helpful conference
- Very well put together training – though through
- This was an informative, enjoyable experience. I leave with skill and information I can pass on
- Very good and well presented course
- I love it
- Thank you Rachel-Rose for putting this on

I give permission for my quotes to be used anonymously	
Yes	13
No	
No Comment	

Permission given for Photograph and Video – All



Mental Health Awareness Training Manual

Contents

What is Mental Health?

What is Mental Illness?

Common Mental Health Problems?

Possible Causes of Mental Health Problems

Mental Health and the Church

Looking After Yourself

Looking Out for Others

When to Refer

Where to Get Help and Support

Aims and Objectives

To:

- Provide information regarding mental health
- Increase knowledge and understanding of mental health
- Recognise signs of mental health distress
- Raise confidence in knowing where to find help
- Raise self-awareness
- Encourage self-care and looking out for others
- PowerPoint presentation, interactive elements simple exercise, pair work, case studies and questions and answer session (Training sessions only).
- Focus on your own well-being throughout the presentation
- If you feel upset, shocked, distressed please speak to a helper (Training session only).

Scriptures:

3 John 1: 2 **Beloved I wish above all things that thou mayest prosper and be in health even as they soul prospereth**

Prosper – to succeed

Health – to have sound health, ,be well in body, to be uncorrupt, be safe and sound, be whole, be in health

Soul – breath, spirit, heart, life, mind

Matthew 22:37/ Luke 10:27 Thou shalt love the Lord thy God with all thy heart 2588 and with all thy soul and with all thy mind (**deep thought, mind, imagination, understanding**)

1 Thessalonians 5.23 And the very God of peace sanctify (make holy, consecrate), you wholly; (**complete to the end, absolutely perfect**), and I pray God your whole (complete in every part, perfectly sound in body), spirit (4151) and soul and body be preserved (5083) blameless (274) unto the coming of our Lord Jesus Christ

Exercise – What words are normally used to describe mental illness?

How does the media, portray mental health? Illness?

What is good mental health?

Mental Health is 'the emotional and spiritual resilience which enables us to enjoy life, survive pain, suffering and disappointment. It is a positive sense of well-being and an underlying belief in our and others dignity and worth. It is influenced by our experience and our genetic inheritance.' (World Health Organisation).

'Mental' is a word which is seen almost exclusively in negative terms – as a term of abuse in the playground, at work and even in the family.

But we are all 'mental' beings – in the same way as we are all 'physical' beings. And mental health is just as important as physical health.

If we are to grow and to flourish, if we are to contribute individually and collectively to society, we need to accept that we are 'mental' beings with emotional and spiritual needs, as well as physical ones.

Good mental health is not just the absence of mental health problems. **Individuals with good mental health:**

- develop emotionally, creatively, intellectually and spiritually
- initiate, develop and sustain mutually satisfying personal relationships
- face problems, resolve them and learn from them
- are confident and assertive
- are aware of others and empathise with them
- use and enjoy solitude
- play and have fun
- laugh, both at themselves and at the world

Definitions

'Mental health' is a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community.

(WHO September 2010)

Characteristics of mental Health:

- Ability to enjoy life
- Resilience
- Balance
- Self-actualisation
- Flexibility

Understanding the characteristics that make up good mental health will help you determine how mentally fit you are.

Mental health - is also known as emotional health, emotional well-being, well-being

Good mental health is characterised by:

- The ability to learn
- Ability to feel, express and manage a range of positive and negative emotion.
- Ability to form and maintain good relationships
- The ability to cope with and manage change and uncertainty
-

Exercise:

Unhealthy_____Healthy

Where would you position yourself on the scale according to: Physical, Spiritual, Mental health? (how you're feeling within yourself)

Mental Health distress

Mental Health problems affect the way we think, feel and behave.

Mental distress covers a wide range of experiences from grief, stress or sadness as a result of everyday life to serious long -term depression or experiences where people lose touch with reality

People can recover completely or have reoccurring episodes.

Mental Illness

‘Any of various psychiatric conditions, usually characterised by impairment of an individual's normal cognitive, emotional, or behavioural functioning, and caused by physiological or psychosocial factors. Also called *mental disease*, *mental disorder*.’

(Medical Dictionary)

Mental Health v. Mental Illness

- Mental Health and Mental Illness are part of the same continuum.
- Mental health relates to a person's ability to manage and cope with feelings that arise as a result of their understanding or experience of social, physical or psychological events
- Knowing how to manage the thoughts and feelings an event has triggered is the key to maintaining good mental health.
- Certain experiences or events could trigger thoughts and feelings that leave some people struggling to cope, which can mildly, moderately, significantly or acutely cause changes in behaviour, ways of thinking and display of emotions.
- The affect may last just a few hours, or many years.
- Everyone is different you may bounce back from a set back while someone else may feel weighed down for a long time.
- Your mental health doesn't always stay the same, it can change as circumstances change and as you move through different stages of life.
- The key to understanding the difference between mental health and mental illness specifically relates to both the lengths of time and the severity of the changes to a person's behaviour, thought patterns and display of emotions.
- The more severe and lengthy the impact of these changes, the more a person may struggle to manage their everyday life and the greater the chances of them developing a mental illness.
- Having a mental illness is not a sign of weakness
- We all have physical health and we all have mental health, they effect each other, so taking care of both is key to a healthy, Christian life.
- It is possible to recover from a mental health problem and go on to live a productive and fulfilling life although for some mental illness can be reoccurring.

Causes of Mental Illness

Mental illness/disorder can be caused by a range of different physical, social and psychological events:

Physical Factors

- Physical conditions brought on by - illness, brain injury, trauma, accident, birth injury or development disorder

Social Factors

- Social problems especially those that cause stress such as - racism, discrimination, poverty, poor housing, violence, unemployment, crime, abuse, relationship problems and noise pollution

Psychological Factors

- Difficult life events can leave people feeling less resilient, with poor self-esteem and self-confidence.
- Other more traumatic events may negatively affect a person's previous ability to maintain self-control or involvement.
- The consequences of both can lead to sustained emotional distress, or may cause a negative effect on a person's thought patterns, emotions or behaviour, long after the initial trigger event.

Spiritual

Exercise: What spiritual factors could cause mental health distress?

- Mental illness/distress is common
- 1:4 people in their lifetime will be affected by mental health issues in the UK

Common Mental Health Conditions

Anxiety and Stress

Anxiety - A feeling of apprehension and fear characterised by physical symptoms such as palpitations, sweating, and feelings of stress

Stress - Is a physical, mental, or emotional response to events that causes bodily or mental tension. Stress is any outside force or event that has an effect on our body or mind

- It can have a healthy purpose signalling a need to be cautious/realistic/responsible
- We also experience anxiety when we are faced with challenges that are new or unknown.
- It can be used creatively
- or can cause discomfort ranging from mild uneasiness to panic attacks

- **Signs** of anxiety and stress manifest in different ways: *low or sad, appetite changes, sleep difficulties, may become fearful, tense, panic attacks - shake, sweat, palpitations and breathlessness.*
- Anxiety and stress can leave a young person with thoughts that life is not worth living.

- **Causes** - *Bullying, bereavement, abuse - physical, emotional or sexual, neglect, domestic violence, parental ill health, exams, relationship difficulties with peers and parental separation*

Depression

- Is the most commonly diagnosed mental health problem in the UK (SLaM NHS Trust 2005)

- In order to be **diagnosed** with depression a person must display five or more of the following symptoms for at least a two week period:
- *Low mood, loss of interest or pleasure, feeling sad or empty, experiencing a marked decrease or increase in appetite, difficulty in sleeping or oversleeping, loss of energy or tiredness, feelings of hopelessness, worthlessness or guilt, difficulties in concentrating or thinking, recurrent thoughts of death or suicide*

- Depression can set in after a stressful experience or event often associated with loss.
- The person may only have negative thoughts, may feel as though no one understands them if they talk about their thoughts or feelings, and so may keep these bottled up inside.
- Low in spirit

Biological Signs and What to Look For

- Physical aches and pains
- Loss of appetite/compulsive eating
- Loss of energy
- Slowing of movement

There may also be burst of anger/irritability, oversensitivity, anxiety

- **Things to look for are** the extremes e.g. *Mania, grandiose thoughts and behaviour, self-absorption, over absorption with course, appearing detached, poor hygiene, physical health, eating problems, aggressive language and words, notable changes over a period of time (few months).*
- *Dramatic changes in appearance, physical health, attendance, irritability, aggression, confusion, distant, argumentative, experiencing them differently.*

Other mental Health Conditions.

- **Bipolar,**
- **Psychosis**
- **Schizophrenia**
- **Anorexia Nervosa**
- **Bulimia Nervosa**
- **Obsessive Compulsive Disorder**

Look After Yourself

How can we help ourselves?

We can help ourselves to good mental health in all sorts of ways including:

- making time to do the things we enjoy
- taking moderate physical exercise
- cutting down on coffee, alcohol, nicotine and other addictive substances
- remembering and celebrating the things we like about ourselves
- keeping things in perspective
- developing and sustaining friendships
- listening to and respecting other people, even if we disagree with them
- asking for help if we feel distressed or upset
- listening to other people who say they feel distressed or upset
- taking as much care of ourselves as we do the people we care for

Looking Out for Others

How to identify, assist and refer

- When an individual is experiencing mental distress often evident in their behaviour or demeanour.
- Change is the most important factor to take into account;
- E.g. where the individual has been previously well dressed and clean begins to take little interest in their appearance or appears unkempt.
- or A drop in motivation or a driven anxiety about work that was not evident previously can both indicate distress.
- A decline in performance and low mood are also indicators of mental distress as is unusual absenteeism, emotional withdrawal or an atypical lack of attention or concentration when in the learning/work setting.

- Other indicators: Vacant staring, compulsive speaking/frequent interruption of lecture, unprovoked crying/giggling, frequent sarcastic and hostile remarks, sudden appearance of speech disorder e.g. difficulty articulating words, inability to sit still.

Agree

- Be clear about what you can do and also what the person can do.
What you can do will again depend on your role, skill and your relationship with the person.
- It will also depend on the level and nature of support the person needs. (eg, welfare, emotional)

Refer

- It is always advisable to remind the person that there are also other sources of help, and to let them know what these are.
- Your decision about where to refer a person will depend on the understanding of the distress that both you and the person have come to.
- In situations where distress is caused by the onset of a mental health problem, the student would be best helped by their GP or by counselling or a pastoral appointment.
- **Act when a person in danger of harming self, harming someone else or being harmed, safeguarding concerns or behaviour related to terrorism**

Review

- It is helpful if you both agree to meet again to discuss how the person is managing.
- This is an important part of the process because it allows you to be certain that the person is getting support and help and is not sinking deeper into difficulties.
- By offering to meet again you are stating that a process has begun in which you are taking the person's need for help seriously, and that you are genuinely interested in helping them.
- By making a formal arrangement, you are also able to draw clear time and role boundaries.
- Agree a time to meet again and clearly state what each of you has committed to do in the meantime.

Record

Remember to record the date, place and outcome of your meetings.

Roles and Referrals: Levels of Involvement

- The extent of involvement in the support of a distressed person is dependent on their role and also on the nature of the distress.
- It is important to offer help and support: that is appropriate to your role and responsibilities/experience and/ or which you have the relevant expertise and time
- Be realistic and do not offer help which is beyond your capabilities.
It is important that both you and the student are clear about the nature and limits of your role.
- If a problem needs specialist help, and is complex or serious it is advisable to refer.
- During a service ushers/greeters/peace keepers to request help from an Elders/pastor (be respectful and patient)
- You may not know what the best source of support would be and there may be more than one problem.
- If you are not sure what the person needs then seek advice from a colleague/team leader/senior or from counselling service
- What is most important initially is to guide the person to a service that they find acceptable.
- It is usually best if, with your support, the individual can take the initiative to approach the service eg counselling. If this seems too difficult for the person it can be helpful to take a more active role, perhaps telephoning the service while they are with you to make an appointment on their behalf, or accompanying them

What to do when a person does not want help

Every person has the right to refuse your offer of support and help. If this happens consider the following:

- Make it clear that you are willing to help and encourage the person to come back at a later date if they so wish
- Give information about where other help can be found
- Record the time, place and outcome of your meeting
- If you are concerned for the person's health or safety, or if a student's behaviour is causing problems for others discuss your concerns
- It is important not to take sole responsibility for the situation
- Your responsibility is to ensure that appropriate help is offered to a person, not to resolve the problem.
- In situations where there is an immediate risk call the emergency services

Confidentiality

- Knowing the boundary of confidentiality within your particular role is very important when supporting students. As volunteers we are bound by confidentiality and must not disclose (outside your team) what has been said to except in very particular circumstances.
- Discretion is essential at all times in order to provide a safe environment within which students can ask for support.
- The person needs to know that any information they give will be treated with respect but that you may need to consult with others and confidentiality may not therefore be possible or in some circumstances advisable.

Suicide

- Suicide is not always a result of depression. It happens in people who have no obvious mental health problem and often in those who have had a personal crisis or have been under great stress or pressure.
- Suicidal thoughts can come on very quickly and a person can act on them suddenly and with very little warning.
- The idea that people who talk about suicidal thoughts will not act upon them is a myth.

- It is a mistake to assume that a person who does not act on suicidal feelings will never do so.
- Thoughts of suicide are distressing and frightening and the person needs help even if they don't have immediate plans to act on them.
- **3 key steps:** 1. **Identify** a person at risk, 2. **ask a direct question** in a calm and non-judgmental way and then 3. **refer the person for help**.
- If the person is at immediate risk they should **not be left alone** and help should be called as a matter of urgency.

Self-Harm

- Some people can have difficult experiences that leave them with distressing feelings that they may struggle to manage. They may not know how to reduce the tension and believe there is no one who can support them.
- People can self-harm in various ways and to varying degrees of severity
- Self-injury, used as a way of expressing deep distress and is Used as a coping strategy
- It is a means of communicating what can't be put into words or thoughts (known as expressing an inner scream)
- Broad term for acts of personal harm – *scratching, cutting, burning, slashing the ones skin, swallowing or putting things inside you, not looking after your own needs properly, high risk behaviour, eating distress and addiction such as alcohol and drugs, some may accidentally or intentionally poison themselves, and intentionally or accidentally set out to cause permanent scarring or death.*

Guidance on how to ask about suicide

1. **Be aware:** Notice the demeanour and emotional state of others. If anything about them causes you to think that they might be having suicidal thoughts act by talking to them about your concerns.
2. **Ask the question:** Do not use euphemisms such as 'Doing something silly'. Ask the question directly and simply, using the word suicide. You can frame the question around what you have observed e.g. 'I've noticed that you are very sad and withdrawn. Sometimes when people are very sad and withdrawn they are thinking about suicide. Is that true for you?'
3. **Ask now:** Don't wait until tomorrow to see how the person is after a night's sleep. It may be too late.
4. **Be ready for the answer:** What will you say or do if the person says 'yes'? Ideally your response should be warm and concerned so that the person feels able to continue talking to you.

If the person says 'no' you have made it clear that you are ready to listen and help. At this point you can put into place the earlier advice on supporting a student in distress.

5. **Listen without judgment or advice:** It can be difficult to refrain from giving advice or reacting to a person talking about wanting to die.

Your instinct will probably be to try to fix their problems. Resist this if you possibly can.

Instead simply accept what is said in a concerned way and allow the person time and space to talk it through. Sometimes people will talk themselves out of wanting to die if given the chance to talk about their feelings.

6. **Keep the person and yourself safe:** If the person has the means to act on their suicidal feelings try to get them to hand them to you. Do not leave the person alone and call for immediate help. If you are concerned for your own or others' safety keep a safe distance and dial 999.

7. **Get help:** Immediate help should be sought if the person is at immediate risk of acting on suicidal thoughts. Current advice is to dial 999 and ask for an ambulance.

DON'T

1. Panic
2. Get side-tracked
3. Get swamped
4. Promise what you can't deliver
5. Ignore the person

DO

1. Assess for risk of suicide
2. Give assurance and information
3. Listen non-judgmentally
4. Encourage person to get professional help
5. Encourage person to use self-help strategies.
6. Know your limitations be honest and clear about this
7. Confer and Refer

Unhelpful Responses

- Offering sympathy rather than empathy
- Not setting boundaries – Presenting self as always available – this is not containing and safe.
- Seduced by offer to split, setting the good guy versus the bad guy i.e. leadership v congregation, could play one leader off against the other.
- Reaffirming person's sense of helplessness. The answers lie within the person.
- Setting up expectations you won't be able to meet so that person ends up feeling disappointed and that they've failed again.
- Not being available when you said you would be.
- Not picking up on the possibility that person may need professional help and suggesting referral possibilities.
- Panicking with the person and therefore playing into their fears that something is wrong with them.

Helpful Responses

- Be clear how much time you have available. Make time to see student again if not available at that moment.
- Empathetically reflect back how the person is feeling.
- Summarise and paraphrase the issue the person is bringing so that they feel heard and contained.
- Help person use their own problem solving resources to prioritise their problem, starting with the issue which most needs addressing eg ask what they would like to change, and what first step they could take to start the process of change.
- Explore what person's expectations of help are. If expectations of others/professionals are unrealistic, it may be useful to give some reality feedback. Look at where the person can realistically get more help and support.
- Sign post where possible.
- Be aware of your own feelings, responses and expectations. Do you feel helpless? Are you very busy and (over)involved? Are you feeling responsible? Everyone is letting the person down, does that make you feel you must be the one person not to let them down? The church has been bad so you must be good? Take a step back and think about your boundaries.
 - a. Find out what keeps them well
 - b. What are the triggers
 - c. What support is needed and from who
 - d. Ask if they have a crisis card and are already receiving support/key worker/social worker

Effective Communication

- When approaching a distressed person some opening responses could include:

'I've noticed you don't seem yourself'

'It sounds like you're having a hard time at the moment'

'Are you looking after yourself?'

'Have there been a lot of changes lately?'

'We all feel like this at times, it usually helps to talk about it?'

'We all need help from time to time; it's worth giving it a go'

Resources and Support Services

- GP/ Health Centre
- Local Community Mental Health Team, Speedwell CMHT
- Counselling Service (individual/ group counselling, workshops, Drop –in sessions, Email Support service, Anxiety drop in, library, referral, **GS staff consultation service**)
- Nearest Hospital A and E dept
- First it's best to look at your own frame of reference ie your meaning and perception of things
- BACP
- Association of Christian counsellors
- Premier Lifeline
- Speak Your Mind – Ruach Radio
- Friends and family

Exercise: 1 thing you've learned, or one thing you will do differently or something you're going to try out?

References

Mental Health Foundation

MIND

Strong's Bible Concordance

The Holy Bible King James version (KJV)

For more information

For details of Professional Counselling/Psychotherapy services delivered by Christians

To book a bespoke training session at your church

Contact:

© Sozo Therapeuo 2018

Telephone: 07496 168 530

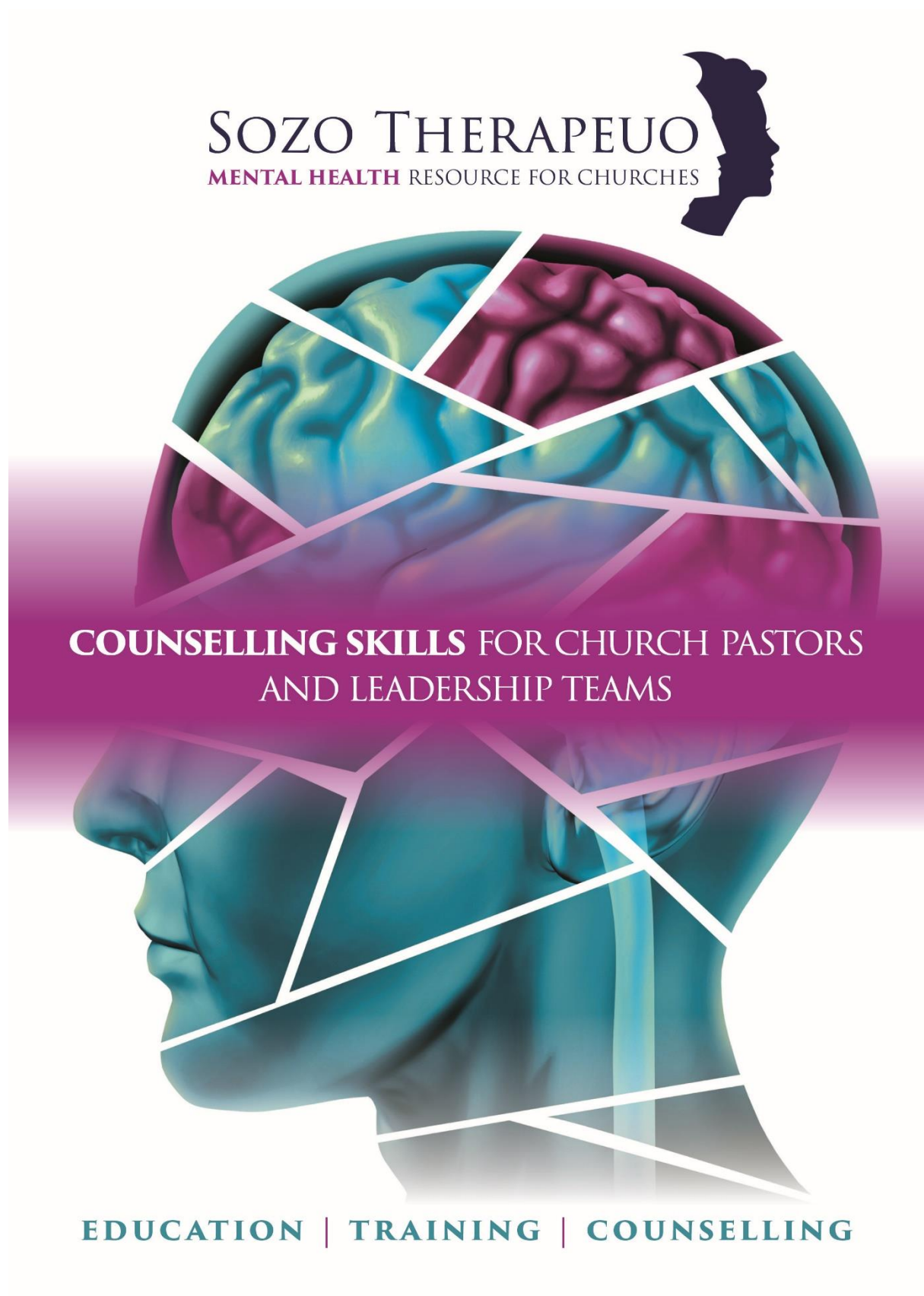
Email: admin@sozotherapeuo.com

Website: www.sozotherapeuo.com

© Sozo Therapeuo 2018

Cover design by CrispelMedia

Appendix 30: Training Manual - Counselling Skills for Pastors and Leadership Teams



Sozo Therapeuo

1 Thessalonians 5: 23

‘...I pray God your whole spirit and soul and body be preserved...’

Training Manual

COUNSELLING SKILLS FOR CHURCH LEADERS

Written by Rachel-Rose Burrell

Content

Biblical Foundations

Creating a Conducive Environment for Counselling

Key Counselling Skills

Self-Awareness

The Different Ways We Communicate

Barriers to Communication

COUNSELLING SKILLS FOR CHURCH LEADERS

Scriptures and Definitions

- **Proverbs 18:21** Death and life are in the power of the tongue: and they that love it shall eat the fruit thereof
- **Matthew 5:37** - But let your communication be, Yea, yea; Nay, nay: for whatsoever is more than these cometh of evil
- **James 1:19** - Wherefore, my beloved brethren, let every man be swift to hear, slow to speak, slow to wrath: KJV
- **Ephesians 4:29**
Let no corrupt communication proceed out of your mouth, but that which is good to the use of edifying, that it may minister grace unto the hearers. KJV

Counselling skills is another term for **Communication Skills**.

What is Communication? – Imparting or exchanging of information by speaking, writing or using some other medium.

A means of sending and receiving information.

The successful conveying or sharing of ideas and feelings (English Oxford Dictionary)

Counselling skills can be described as 'the art of listening' and can be practised by almost anybody not just people in certain roles

Counselling Skills enables clear communication to take place.

Disclaimer

- You will not be a qualified counsellor at the end of this training manual, we hope you will feel more confident in your ability to practice good communication/counselling skills which can be used at work, church and in your personal life, and improve the quality of your relationships.

Exercise 1.***List the Different Ways We Communicate?******How do you know when your communication is successful?*****What is Counselling?**

- A professional relationship between the help seeker and the counsellor/therapist.
- Counselling involves a series of formal sessions where the therapist and the client talk about the client's issues and feelings. Even short-term therapy typically involves six to 12 sessions. The sessions take place at a regular, agreed time and in a 'safe' private place where the client and therapist will not be overheard or interrupted.
- Therapy may involve talking about life events, feelings, emotions, relationships, ways of thinking and patterns of behaviour. The therapist will listen, encourage and empathise, but will also challenge to help the client to see their issues more clearly or in a different way (BACP)

What Counselling is not:

- A Chat
- Making a new friend
- Giving advice
- Giving your opinion
- Accessible 24 hours a day
- Easy

Knowledge, Skills and Understanding

Why people seek/need help?

- Unable to cope with daily living
- Having a specific problem to resolves

Why do people have therapy?

People seek counselling to help them resolve emotional, psychological and relationship issues. They may be experiencing difficult and distressing events in their lives, such as bereavement, divorce, health issues or job concerns. Or they may have more general underlying feelings of anxiety or dissatisfaction with life.

Some clients feel isolated and have no one else to talk to, but even people with supportive family and friends can find it difficult to talk to them about feeling anxious or depressed. Or they may just find it easier to talk about personal, family or relationship issues with an independent and professional therapist.

Helper's role:

- To challenge people to take responsibility for their own lives
- To enable the help seeker to trust their inner resources

Core Conditions of Counselling

- **Empathy** – develop an understanding of how the other thinks and feels
- **Congruence** – genuineness, authenticity
- **Unconditional positive regard** –total acceptance
- **Self regard** – respect for self and others

- **Self actualisation** – moving toward fulfilling ones potential

What helping conversations involve:

A number of things trying to achieve as a helper:

Engaging the speaker in being comfortable enough to speak openly.

- Helping the speaker to deepen exploration of the issues he/she wants to discuss.
- Enabling the release of emotions.
- Making sense of the issues.
- Moving on to deal with the issues.
- Ethics and confidentiality

When disclosure is necessary

- Harm to self or another, danger of being harmed
- Crime/terrorism
- Children/Safeguarding concerns

Qualities of an Effective Communicator

Exercise 2: What are the qualities of an effective communicator?

Reflect on your communication style – what works well? What needs improvement?

Creating a Conducive Environment for Counselling

- Prepare the environment
- Physical layout
- Room temperature
- Barriers
- Distractions
- Prepare yourself

Meetings/Structure

The Three Stage Model

- Stage one: Relationship-building
- Stage two: Exploring and clarifying
- Stage Three: Action and closing

There should be a clear beginning, middle and ending

- Set ground rules e.g. one person speaks at a time
- Where possible agree the purpose/focus of the meeting
- At the end of the meeting clarify the outcome, goals, homework or plan and agree the date and time of next meeting if appropriate
- Stick to time boundaries, start and finish on time
- Be respectful

Key Counselling Skills

Listening To Others

Attending - Listen with undivided attention, without interruption and without letting your mind wander, remembering details, eye contact, paying attention to body language and facial expression

Eye contact- In western cultures looking someone in the eye is seen as a sign of honesty, integrity or that you have their undivided attention. In certain Asian cultures, it can be seen as a sign of disrespect or rudeness.

When using counselling skills always be culturally aware

Rapport building - Being welcoming and respectful, acceptance
Eg smile, being genuine, showing interest, body language, care

Focussing – Prioritise by asking helpee to identify the most pressing issues

Eg What are the 3 most important issues

Minimal encouragers – affirming non verbal interventions

‘Aha’, ‘Uh huh’, ‘Mm’, ‘Yes’, ‘Oh’? ‘I see’, ‘Right’, repetition of one or two key words – reassures the person you are listening

Eg When I think about her I get really angry - Angry, I hate my job -You hate

Silence – Allows helpee to tell their story, to feel heard and validated and the helper a deeper understanding and time to consider appropriate response
It is not your role to fill the silence, especially if you feel uncomfortable

Paraphrasing – Reflecting back key points, re-phrasing information using different words – helps to check accuracy and level of understanding.

Use simple points and clear language, make your paraphrase shorter than the helpee’s statement.

Eg You are saying...is that right? You seem to be sayinghave I understood you correctly?

Mirroring - Attending and Reflecting the helpees statements back to them, using the helpees words, mirrors back exactly what was said. Choose words carefully.

Hearing someone else say it can bring a different perspective

‘I’m fat, ugly and stupid’ - You are or you feel.....

Reflecting feelings – Picks up on the emotion shown by the client as they are telling their story, and putting them into words, picking up on the feeling in the message, sometimes you have to assist the helpee find the right words

Eg I was so angry I was all over the place, I wanted to explode

Empathy - Seeing and feeling from another’s point of view ‘Walking in the person’s shoes’. Putting yourself in the other person’s skin.

Sympathy - associated with condolences, giving comfort, pity

Clarifying - Use of a question to get a better understanding of the helpee's story, to expand on what they mean, you should always ask for clarity if you don't understand, never just go along with it - lose credibility.

Eg Family member is sick, with an illness you've never heard of.

'Could you say a bit more', 'could you explain that a little more'

Clarifying conflicting/mixed feelings - hard to express emotions

Eg bereavement after a long illness feeling sadness and relief

Child leaving home, spouse has had a promotion

Use of Questions – Used for understanding and clarity not probing, to be nosey or to interrogate the helpee. Help to move the conversation along

Closed questions – More directive, Respond with a yes or no answer, factual, narrow a conversation down (Do you..? Is it..? Have you..?)

Open questions - Allows the helpee to speak more about the issues, allows more freedom and choice, they open up a conversation (What? When? How? Where?)

Curiosity - Check yourself – why am I asking this question, for whose benefit?

Why? questions - can lead to guilt and feeling condemned, judged

Exercise – think of examples that demonstrate open and closed questions?

Summarising - Drawing together feeling, thoughts, ideas expressed.

- Helper checking for accuracy
- Longer Paraphrase
- It is a useful way to reflect the key points before bringing the meeting to a close.

Active Listening

- Unlike everyday conversations
- Listening to understand instead of listening to respond
- Assists in forming a trusting, mutually respectful relationship.

Helpee feels safe and secure enough to discuss difficult issues.

Listening using all the senses:

- Ears- To get the words spoken and tone of voice
- Eyes – To get the body language, posture, facial expression
- Your Mind – The underlying message, what they might not be saying
- Yourself – Noting your own reactions and responses
- Spiritual discernment

Knowing when not to listen

Sometimes allowing someone to open up is inappropriate, such as when you know you don't have the time to listen. In these instances you need to be assertive enough to interrupt if necessary and be firm about suggesting an alternative. This action is in the help-seeker's best interests as well as your own because to open up and then be left without resolution is unhelpful.

Be clear about what you can offer and recognise the limits of your competence. To continue listening to issues that fall outside of what you can deal with is unhelpful, unless it's in order to enable the person to seek appropriate help.

You may also need to stop someone telling you more about an issue in which you have a bias or interest which would prevent you from being attentive and impartial.

Working with crisis and risk

Sometimes when faced with a challenging situation that poses issues of safety and ethical responsibility, you can feel pressured to make rapid decisions.

Generally, you have time to consult, and if there's any question of breaking confidentiality, be sure to consult, especially if breaking confidentiality is without the help-seeker's consent.

To discriminate between **crisis, urgency, and importance**, ask yourself:

1. Do I need to take action right now?
2. Who am I protecting by acting immediately – is it just myself?
3. Do I need to take action today?
4. What harm is likely if I don't take immediate action? Is the risk greater if action is delayed long enough for me to consult?
5. Is there any risk of harm, and to whom, from taking immediate action?
6. Which risk of harm carries the greatest weight?

Touch

- Means different things to different people
- There are cultures where touching is limited- it is mistrusted, or prohibited particularly across genders
- It is a powerful expression, that may be experienced as caring or abusive

Silence

Silence can express many things:

Anger, fear, boredom, respect, embarrassment, sadness, contempt, processing

Safety and Accountability

Reviewing

When reviewing, not only is it important to acknowledge what you've worked on together, but also to reinforce the learning that has taken place.

In the reviewing process use questions such as:

- Looking back to the beginning can the help-seeker remember how he felt then?
- What progress and decisions have been made
- Can you together identify what has been helpful and unhelpful?
- How do the help-seeker and you feel about difficulties that haven't been resolved?
- What may be future stress points?
- How will the help-seeker recognise indicators that show that he may need to take action?
- What has been learned through the helping relationship that will help?
- How can the work that has been done be acknowledged?
- Acknowledging and celebrating any successes or growth.

Recording

- Taking notes, administrative tasks, storing notes
- Consider confidentiality
- Data Protection and Freedom of information Act (follow church church's policies and procedures)

Storing Records

- When an individual is absent for any reason, someone else may need to pick up his/ her work .
- Note-keeping is a way of reflecting on your work.

- Aids memory
- Individuals and organisations can find themselves subject to complaints and be required to justify and explain their actions.
- Notes could be subpoenaed

Self-Care

Self-care includes:

- Positive contact with individuals, such as family, friends, work colleagues, and with social groups.
- Activities such as walking, swimming, sports, going to the gym, dancing, gardening, decorating.
- More sedentary activities, such as reading, sauna, watching TV, relaxation exercises, journal/diary-writing, drawing/ painting.
- Spiritual or contemplative things such as praying, being in beautiful and natural surroundings, looking at art, listening to music, writing poetry.
- Activities that support your self-esteem, such as trying new challenges and new learning, taking care of your appearance, coaching, counselling, positive affirmations.
- Balance

Be clear about what you can offer and recognise the limits of your competence. To continue listening to issues that fall outside of what you can deal with is unhelpful, unless it's in order to enable the person to seek appropriate help.

You may also need to stop someone telling you more about an issue in which you have a bias or interest which would prevent you from being attentive and impartial.

Self-Awareness

Understanding of self-awareness in developing effective counselling skills

An important aspect of your qualities and skills as a listening helper is your self-awareness.

- Listening to self
 - Self-acceptance
 - Own prejudices, attitudes and values
 - Own ability to achieve core conditions when disclosure is necessary
-
- When we block self-knowledge, we tend to make poor decisions for ourselves. When we use energy in maintaining defences, we're distracted from listening well (to ourselves and others).

For anyone using counselling skills, the aim is to be more aware and less afraid of your internal world, for these three reasons:

1. So that you become free to concentrate on the speaker without your own baggage getting in the way
2. Because the more you understand and accept yourself, the more likely you are to understand and accept others
3. So that you model the ability to be in touch with your inner self, which provides valuable information, known as emotional intelligence.

Understanding Yourself

Self-knowledge

In order for you to be a non-judging, reliable, and an attentive listener, you must develop an increasing awareness of yourself and what you're bringing to the helping relationship.

Aspects of yourself to bear in mind include:

- Your values, prejudices, assumptions, and internal 'rules'
- Your need to be regarded by the speaker in a certain way (for example, to be liked, needed, or viewed as a capable expert)
- Your own emotional triggers or blind spots
- Your ways of defending yourself against difficult feelings

The Different Ways We Communicate

Understanding your communication style

Good communication skills require a high level of self-awareness. Understanding your personal style of communicating will go a long way toward helping you to create good and lasting impressions on others. By becoming more aware of how others perceive you, you can adapt more readily to their styles of communicating; you can make another person more comfortable

Do you know how your communication style is perceived?.

It is important to understand how your communication style is interpreted by others to avoid miscommunication and misunderstandings. The goal is communicate with assertion and avoid an aggressive, passive-aggressive or passive style of communication.

There are 4 basic communication styles:

Aggressive, Passive, Assertive and Passive-Aggressive

Evaluate and Improve

Aggressive Communication

___ You choose and make decisions for others.

___ You are brutally honest.

___ You are direct and forceful.

___ You are self-enhancing and derogatory.

- ___ You'll participate in a win-lose situation only if you'll win.
- ___ You demand your own way.
- ___ You feel righteous, superior, controlling – later possibly feeling guilt.
- ___ Others feel humiliated, defensive, resentful and hurt around you.
- ___ Others view you in the exchange as angry, vengeful, distrustful and fearful.
- ___ **The outcome** is usually that your goal is achieved at the expense of others. Your rights are upheld but others are violated.
- ___ **Your underlying belief system** is that you have to put others down to protect yourself.

Passive Communication

- ___ You allow others to choose and make decisions for you.
- ___ You are emotionally dishonest.
- ___ You are indirect and self-denying.
- ___ You are inhibited.
- ___ If you get your own way, it is by chance.
- ___ You feel anxious, ignored, helpless, manipulated, angry at yourself and/or others.
- ___ Others feel guilty or superior and frustrated with you.
- ___ Others view you in the exchange as a pushover and that you don't know what you want or how you stand on an issue.
- ___ **The outcome** is that others achieve their goals at your expense. Your rights are violated.
- ___ **Your underlying belief** is that you should never make someone uncomfortable or displeased except yourself.

Passive-Aggressive Communication

- ___ You manipulate others to choose your way.

- ___ You appear honest but underlying comments confuse others.
- ___ You tend towards indirectness with the air of being direct.
- ___ You are self-enhancing but not straight forward about it.
- ___ In win-lose situations you will make the opponent look bad or manipulate it so you win.
- ___ If you don't get your way you'll make snide comments or pout and be the victim.
- ___ You feel confused, unclear on how to feel, you're angry but not sure why. Later you possibly feel guilty.
- ___ Others feel confused, frustrated, not sure who you are or what you stand for or what to expect next.
- ___ Others view you in the exchange as someone they need to protect themselves from and fear being manipulated and controlled.
- ___ **The outcome** is that the goal is avoided or ignored as it causes such confusion or the outcome is the same as with an aggressive or passive style.
- ___ **Your underlying belief** is that you need to fight to be heard and respected. If that means you need to manipulate, be passive or aggressive, so be it.

Assertive Communication

- ___ You choose and make decisions for you.
- ___ You are sensitive and caring with your honesty.
- ___ You are direct.
- ___ You are self-respecting, self-expressive and straight forward.
- ___ You convert win-lose situations to win-win ones.
- ___ You are willing to compromise and negotiate.
- ___ You feel confident, self-respecting, goal-oriented, valued. Later you may feel a sense of accomplishment.
- ___ Others feel valued and respected.
- ___ Others view you with respect, trust and understand where you stand.

___ **The outcome** is determined by above-board negotiation. Your rights and others are respected.

___ **Your underlying belief** is that you have a responsibility to protect your own rights. You respect others but not necessarily their behaviour.

The aggressive style is essential at certain times such as:

- when a decision has to be made quickly;
- during emergencies;
- when you know you're right and that fact is crucial;
- stimulating creativity by designing competitions destined for use in training or to increase productivity.

Passiveness also has its critical applications:

- when an issue is minor;
- when the problems caused by the conflict are greater than the conflict itself;
- when emotions are running high and it makes sense to take a break in order to calm down and regain perspective;
- when your power is much lower than the other party's;
- when the other's position is impossible to change for all practical purposes (i.e., government policies, etc.).

Remaining aware of your own communication style and fine-tuning it as time goes by gives you the best chance of success in business and life.

Barriers to Communication

Blocks to good communication skills:

However willing and keen you are to listen and be helpful, some things can interrupt your listening, such as the distractions of a busy or unsuitable environment,

Exercise: Think of other examples of barriers to communication

- You can also suffer from practical internal distractions, such as being hungry, thirsty, or needing the toilet.
- You can be disrupted from careful listening by worries such as being unsure what to say next, not knowing anything about the specific topic the help- seeker has brought up, or panic about disclosures that have been made.
- People tend to carry around prejudices, assumptions, and needs (such as the need to be liked or seen to be competent) that can interfere with their ability to really listen.

Poor Communication

Poor communication is the result of many factors. The list represents some common barriers:

- Sender has poor knowledge of the subject or is inadequately prepared.
- Sender does not believe in the message
- Receiver is not interested in the subject.
- Cultural differences exist between communicators
- Status/power differences (leader-member) exist between communicators.

One of the communicators has negative or hostile reactions to the other.

Outside interference or distractions have occurred.

- Pressure of time does not allow effective communications to occur

Factors that hinder good responding:

- Poor communication
- Leading questions
- Multiple questions

Factors that help good responding

- Focus on the individual
- Establishing good relationship
- Need for and the use of silence

Spiritual Abuse

- Spiritual abuse is the mistreatment of a person in the name of God, faith, religion, or church at the expense of their spiritual well being.
- It includes various forms of control, domination or manipulation by someone or a group who has authority within a spiritual setting.

Religious abuse refers to abuse administered under the guise of religion, including harassment or humiliation, possibly resulting in psychological trauma.

Spiritual abuse also includes:

- Psychological and emotional abuse with the objective of unnatural domination and control of the victim for self-aggrandising purposes by the perpetrator;
- Physical abuse that includes physical injury, deprivation of sustenance;
- Sexual abuse;
- Any act by deeds or words that demean, humiliate or shame the natural worth and dignity of a person as a human being;
- Submission to spiritual authority without any right to disagree; intimidation;
- Unreasonable control of a person's basic right (personal autonomy) to make their own decisions (freewill, volition) on spiritual or natural matters;

- False accusation and repeated criticism by negatively labelling a person as disobedient, rebellious, lacking faith, demonised, apostate, enemy of the church.

When to make a referral and to who

When disclosure is necessary/Breaching confidentiality

- Harm (risk of self-harm or harm to others)
- Crime

Refer to GP, AandE, Network of community resources

Action: Seek advice and/or refer

A popular misconception is that asking about **suicide** brings on the act, but no evidence supports this.

When someone is in a very low state, be sure to:

Ask questions such as, ‘How low do you feel?’ , ‘Have you ever felt like you would rather not be here?’ , or ‘Do you think about not waking up in the morning?’ ,

Mental Ill-health

Mental ill-health spans a broad spectrum from mild to moderate depression and anxiety through to more severe disorders such as schizophrenia.

If you ever have doubts whether a person’s behaviour could indicate a serious mental-health problem,

Action: seek advice and/or refer.

You need to know if someone is taking medication and what effects this may have - for example feeling ‘spaced out’ and therefore unable to engage in the helping process properly.

- Check the extent and frequency of the problem (the person may minimise or conceal the problem).
- Support the help-seeker to find specialist help.
- If problem is not life-threatening, shift focus to underlying or other issues, as the help-seeker wishes.

Seek advice and refer.

Culture

You cannot possibly know about every single culture,

- but you can expose yourself to different cultures and experiences of oppression through reading, watching television, and film documentaries, opening yourself to friendship, or being a volunteer with people from different ethnic backgrounds to yourself.

- In the helping relationship

you can invite discussion about expectations, concerns, and the impact of

cultural background on the individual's life and on the work you do together.

Supporting Yourself?

Consultation, Peer Network, Debriefing sessions and Supervision

- Are all ways of supporting and looking yourself

What about those who never ask for help?

- Be approachable, open, smile, available

Stretching your listening skills

- As a listening helper you need to stretch your capacity to listen to a person who may have very different life experiences from your own.

Summary

Counselling skills also involves:

- Creating a safe environment
- Setting effective boundaries so that people know where they stand and what's expected of them and you during the meeting
- Working in a non-shaming way so that people can disclose their concerns
- Allowing people to work at their own pace
- Not pushing or forcing individuals to do things they don't want to do
- Letting people find out what works best for them
- Allowing people to find their own solutions rather than giving advice or answers, while at the same time offering a range of options

How you use these tools is dependent on your life experience, personality, values, prejudices, practice, and level of self-confidence. To build confidence and improve communication skills Keep Practicing!

Practice Session

- Get into groups of 3
- Choose one of the examples provided
- Person 1 speaks for 3 minutes, then 3 minutes feedback (helpee, helper and observer), Person 2 practises counselling skills through listening and asking questions etc, Person 3 Observes only, no comments until feedback.
- Then Person 2 speaks for 3 minutes and feedback, then person 3
- Everyone should experience being the helpee, helper and observer.

Role Play Scenarios

Choose One if you do not have your own material to work with.

1. Talk about a work situation you have found challenging.
2. Describe a situation at church which involved you having to deal with conflict.
3. When was the last time you felt one of these emotions? What caused you to feel that way?
Sadness, Anger, Fear.
4. Talk about something that happened to you in the last week

Feedback from each person should include the following

- What did it feel like?
- What did you notice?
- What was positive?
- What could be improved/worked on?

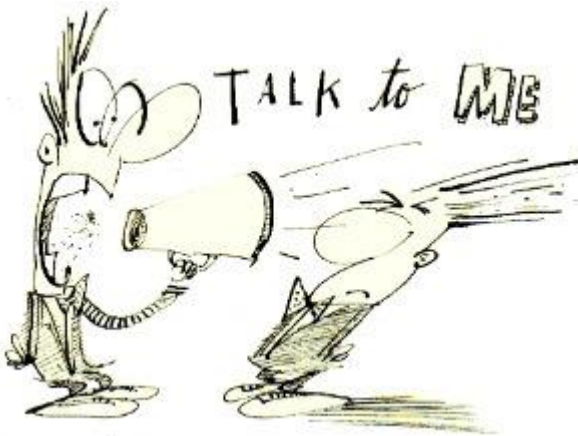
References

Counselling Skills for Dummies by Beales and Whitten

Foundation Certificate in Counselling Skills – The Counselling Centre

Key Counselling Skills Explained – Counselling Tutor online

www.getselfhelp.co.uk



For more information

For details of Professional Counselling/Psychotherapy services delivered by Christians

To book a bespoke training session at your church

Contact:

© Sozo Therapeuo 2018

Telephone: 07496 168 530

Email: admin@sozotherapeuo.com

Website: www.sozotherapeuo.com

© Sozo Therapeuo 2018

Cover design by CrispelMedia

Bibliography

Abu-Rayya, H. M. & Khalil, M. (2009). The Multi-religion identity measure: A new scale for use with diverse religions. *Journal of Muslim Mental Health*, 4, pp. 124-138.

Acheson, D. (1998). Independent Inquiry into Inequalities in Health, *Department of Health and Social Care*.

Adams, S. (2011). *Faith 'good for your health'*. Home News Health. Available from: <<https://www.telegraph.co.uk/.../Faith-good-for-your-health.html>> [Accessed 16 August 2016].

Adedibu, B. (2012). *Coat of Many Colours: The origin, growth, distinctiveness and contributions of Black Majority Churches to British Christianity*. Gloucester: Wisdom Summit.

Ai, A. L. C. Peterson, C. T. N. Tice, T.N. Bolling, S.F. & Koenig, H.G. (2004). Faith-based and secular pathways to hope and optimism subconstructs in middle-aged and older cardiac patients, *Journal of Health Psychology*, 9, 3, pp. 435-450.

Akbar, N. (1994). *The Community of Self (Revised)*. Florida: Mind Productions and Associates

Akhazemea, D. (2015). The reshaping of religious and social landscape of Britain: The influence of the black majority churches, *Transmission*, Spring, pp.24-26.

Alarcón, R. D. (2018). Cultural perspectives on migration and psychopathology, *Cultural Psychiatry*, 35, 2.

Aldred, J. (2007). Black churches contributing to cohesion or polarising Christians and other faith groups? *Churches Together in England*.

Aldred, J. (2016). Pentecostalism in Britain today: Making up for failures of the past, *Churches Together in England*.

Al-Issa, I. (1995). The illusion of reality or the reality of illusion: Hallucinations and culture, *British Journal of Psychiatry*, 166, pp. 368-373.

Allen, D. (1994). *The Unfailing Stream: A charismatic history in outline*. Tonbridge: Sovereign World

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders DSM-5*. Washington DC: American Psychiatric Publishing

Anderson, A. (2000). The Pentecostal Gospel, Religion and Culture in African Perspective. *Graduate Institute for Theology and Religion, University of Birmingham*.

- Association of Christian Counsellors (2018). Vision and values, *Pastoral care*
- Aten, J.D. & Hernandez, B.C. (2004). Addressing religion in clinical supervision: A model. *Psychotherapy: Theory, Research, Practice, Training*, 41, pp. 152–160.
- Bager-Charleson, S. (2014). *Doing Practice-based Research in Therapy*. London: Sage
- Baider, L. & Sarell, M, (1983). Perceptions and causal attributions of Israeli women with breast cancer concerning their illness: The effects of ethnicity and religiosity, *Journal of Psychotherapy and Psychosomatics*, 39, 3, pp.136-143.
- Balmer, N. (2015). *Mental health: How much does the UK spend on research?* Wellcome Trust.
- Barnes, R. (2008). The advantages of CAQDAS, *Oxford Textbooks*
- Battuta, I, (1355). The Travels (Rihla) of Ibn Battuta. Hood Hood Book Ltd
- Bazeley, P. & Jackson, K. (2013). *Qualitative Data Analysis: Practical strategies*. London: Sage
- BBC World Service. (2009). Christianity, the story of Africa, *BBC*
- BBC. (2009). Pentecostalism, *BBC*
- BBC. (2009). Metropolitan Museum of Art, *BBC*
- Beardsworth, A. & Keil, T. (1992). The vegetarian option: varieties, conversions, motives and careers, *Sociological Review*, 40, pp. 253-293.
- Beckford, R. (1998). *Jesus Is Dread*. London: Darton, Longman and Todd Ltd
- Bergin, A.E. & Payne, I.R. (1991). Proposed agenda for a spiritual strategy in personality and psychotherapy, *Journal of Psychology and Christianity*, 10, pp.197–210.
- Bhopal, R. S. (2007). *Race, Ethnicity and Health in Multicultural Societies*. Oxford: University Press
- Bhugra, D. (1997). *Psychiatry and Religion: Context, consensus and controversies*. London: Taylor and Francis
- Bhui, K. & Bhugra, D. (2003). Explanatory models in psychiatry, *British Journal of Psychiatry*, 183, 2, p.170.
- Bird, V. Leamy, M. Le Boutillier, C. Williams, J. & Slade, M. (2011). Spirituality and Culture. *Rethink Institute of Psychiatry*, 4, p. 35.

- Bisnauth, D. (1989). *History of Religions in the Caribbean*. Jamaica: Kingston Publishers Limited
- Black Mental Health UK. (2017). *BMH UK*
- Blacker, K. H. & Wong, N. (1963). Four cases of autocastration, *Archives of General Psychiatry*, 8, pp.169–176.
- Blackman, P.S. (2003). A stitch in time, *Mental Health Review*, 8, 2, p.3.
- Blaxter, L. Hughes, C & Tight, M. (2010). *How to Research*. Berkshire: Open University Press
- Boahen, A. (1990). *UNESCO General History of Africa 1880-1935*. London: James Currey Ltd
- Boyatzis, R.E. (1998). *Transforming Qualitative Information*. Thousand Oak: Sage
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology, *Qualitative Research in Psychology*, 3, pp.77-101.
- Braun, V. & Clarke, V. (2013). *Successful Qualitative Research: A practical guide for beginners*. London: Sage
- Breedvelt, J. (2003). Better or worse: A longitudinal study of the mental health of adults in Great Britain, national statistics, *The Mental Health Foundation*.
- Bremner, S. (2016). Black majority megachurches in London: Aspiring to engender change, *University of Birmingham*.
- Brierley, P. (2009). Pentecostal Christians in London, *Future First*, 1, pp. 3-4.
- Brierley, P. (2013). *London's Churches Are Growing*. Kent: ADBC publishers
- Brierley, P. (2012). The London church census, *London City Mission*.
- Brierley Consultancy. (2016). Christian Statistics, *The Faith Survey*.
- British Association for Counselling & Psychotherapy. (2011). Ethical Framework for the Counselling Professions. *British Association for Counselling & Psychotherapy*
- British Council of Churches. (1976). The new Black presence in Britain: A Christian scrutiny, *British Council of Churches Working Party on Britain as a Multi-Racial Society*.
- British Mindfulness Institute. (2017). Mindfulness-based stress reduction, *British Mindfulness Institute*.

- Brown, D. (1999). *Black Majority Church -What's in a name?* London: Barnardo's CANDL Project.
- Bryman, A. (2008). *Social Research Methods*. (3rd edition). New York: Oxford University Press
- Bunn, A. & Randall, D. (2011). Health Benefits of Christian Faith, *Christian Medical Fellowship*.
- Burgess, K. (2016). Anglican faith sinks in sea of diversity, *The Times*, March 28 2016.
- Calley, M. (1962). Pentecostal sects among West Indian migrants, *Race & Class*, 3, pp. 55–64.
- Carroll, M. (2013). *Religion, spirituality and psychiatry*. Los Angeles CA: Inner Peace Publishing.
- Cassen, R. & Kingdon, G. (2007). Tackling low educational achievement, *Joseph Rowntree Foundation*.
- Centre for Mental Health. (2016). Does mental ill health cost £105 billion a year? *Department of Health*
- Charman, P. (1979). *Reflections, Black and White Christians in the City*. Zebra Project The Centre for Black and White Christian Partnership,
- Christian Research. (2006). English Church Census, *Economic and Social Research Council*.
- Churches Together in England. (2015). Black and Multicultural Churches UK Directory, *Christian Today*
- Cinnirella, M. & Loewenthal, K.M. (1999). Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study, *British Journal of Medical Psychology*, 72, 4, pp. 505-524.
- Clarke, M. (2015). Pentecostal spirituality as lived experience: An empirical study of women in the British black Pentecostal church, *School of Philosophy, Theology and Religion, College of Arts and Law, University of Birmingham*
- Clarkson, P. (2002). *The Transpersonal Relationship in Psychotherapy*. London: Whurr
- Clegg II, L. (1996). When Black Men Ruled the World, Long Beach, California: *The Clegg Series*

- Cobb, M. & Robshaw, V. (1998). *The Spiritual Challenge of Health Care*. London: Churchill Livingstone
- Cochrane, R. & Sashidharan, S.P. (1995). Mental health and ethnic minorities: A review of the literature and implications for services, *University of Birmingham and Northern Birmingham Mental Health Trust*.
- Cook, C.H. (2011). Recommendations for psychiatrists on spirituality and religion. *Royal College of Psychiatry*.
- Cook, C.H. Powell, A. & Sims, A. (Eds.), (2009). *Spirituality and Psychiatry*. London: Royal College of Psychiatry.
- Cook, C.H. Goddard, D. & Westall, R. (1997). Knowledge and experience of drug use amongst church affiliated young people, *Drug Alcohol Dependence*, 46, pp.9-17.
- Community Care and BBC News. (2015). Funding for NHS Mental Health, *Community Care and BBC News*.
- Community Development and Health Network. (2009). Health inequalities, *Public Heath Well*
- Conkin, P.K. (1997). *American Originals: Homemade varieties of Christianity*. The University of North Carolina Press
- Cooper, L. (2013). Black and ethnic minority Christians lead London church growth, *Evangelical Alliance*
- Coppock, V. and Hopton, J. (2000). *Critical Perspectives on Mental Health*. London: Routledge
- Copsey, N. (2001). Forward in faith: An experiment in building bridges between ethnic communities and mental health services in East London, *Sainsbury Centre for Mental Health*
- Corcoran, M. (2011). How a humble preacher ignited the Pentecostal fire. *Cox News Services*
- Cornah, D. (2006). The impact of spirituality on mental health, *Mental Health Foundation*.
- Counselling Directory. (2016). Statistics about mental health treatment and services, *Counselling Directory*

- Cox, H. (2001). *Fire from Heaven: The rise of Pentecostal spirituality and the reshaping of religion in the 21st century*. Cambridge, MA: Da Capo Press
- Coyle, A & Lochner, J. (2011). Religion, spirituality and therapeutic practice, *British Psychological Society*, 11, 24, pp. 264-266.
- Coyte, M. (2011). In practice: The work of the national spirituality and mental health forum. *Openmind Mental Health Magazine*, 169, pp. 20-21.
- Crossley, J.P. & Salter, D.P. (2005). A question of finding harmony: A grounded theory study of clinical psychologists' experience of addressing spiritual beliefs in therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 78, pp. 295–313.
- Cutland, T. (2000). *Intrinsic Christianity, Psychological Distress and Help-seeking*. University of Leeds.
- Dance Movement Therapy. (2017). Dance movement therapy, *Good Therapy*
- D'Ardenne, P. & Mahtani, A. (1999). *Transcultural Counselling in Action*. London: Sage
- Davidson, R.J & Begley, S. (2012). *The Emotional Life of Your Brain*. New York: Penguin Publishing
- Davidson, R. in Decker, E. (2015). Richard Davidson: Advancing the state of mindfulness, *Spirituality and Health*.
- Darwin, C. (1874). *The Descent of Man*. Penguin Classics (republished 2004)
- Dein, S. (2002). Transcultural psychiatry (letter). *British Journal of Psychiatry*, 181, pp.535–536.
- Dein, S. (2004). Working with patients with religious beliefs. *Advances in Psychiatric Treatment*, 10, pp. 287-94.
- Dein, S. & Littlewood, R. (2005). Apocalyptic suicide: From a pathological to an eschatological interpretation, *International Journal of Social Psychiatry*, 51, 3, pp. 198-2010.
- Dein, S. & Littlewood, R. (2007). The voice of God, *Anthropology and Medicine*, 14, pp. 213-228.
- Dein, S. Cook, C.C.H. Powell, A. Eagger, S. (2010). Religion, spirituality and mental health, *The Psychiatrist*, 34, pp. 63-64.

Dein, S. Cook, C. C. H. & Koenig, H.G. (2012). Religion, spirituality, and mental health: Current controversies and future directions, *Journal of Nervous and Mental Disease*, 200, 10, pp. 852-855.

Denscombe, M. (1988). *The Good Research Guide: For small-scale research projects*. Buckingham: Open University Press

Department of Health. (2011a). An NHS and social care model for improving care for people with long term conditions, *Department of Health*.

DeSilva, R. Aggarwal, N.K. & Lewis-Fernandez, R. (2015). The DSM-5 cultural formulation interview and the evolution of cultural assessment in psychiatry, *The Psychiatric Times*, 32, 6.

Diop, C.A. (1987). *Precolonial Black Africa*. France: Lawrence Hill Books

Doering, S. Muller, E. Kopcke, W, Pietzcker, A. Gaebel, W. Linden, M. Muller, P.

Muller-Spahn, F. Tegeler, J. & Schussler, G. (1998). Predictors of relapse and rehospitalization in schizophrenia and schizoaffective disorder, *Schizophrenia Bulletin*, 24, pp. 87-98.

Donovan, K. (2006). Blair commends Black Majority Churches' role in mental health services, *Christian Today*.

Dossey, L. (1996). *Prayer is Good Medicine: How to reap the healing benefits of prayer*. San Francisco: Harper Collins

Duffield, I. (1981). Black people in Britain: History and the Historians, *History Today*, 31,9.

Duncan, C. (2016). Prayer. *Duke Medical News*.

Dura-Vila, G. Hagger, M. Dein, S. & Leavey, G. (2011). Ethnicity, religion and clinical practice: A qualitative study of beliefs and attitudes of psychiatrists in the United Kingdom, *Mental Health, Religion & Culture*, 14, 1, pp. 53-64.

Eagger, S. Richmond, P. & Gilbert, P. (2001). Engaging the Spirit: NIMHE spirituality and mental Health project. In *Spirituality and psychiatry, The Royal College of Psychiatrists*.

Edge, D. (2010). Conversations with God or psychopathology? Black Caribbeans, Pentecostalism and mental health practice. First International Conference of the British Association for the Study of Spirituality, *Spirituality in a changing world*

- Eisenberg, L. (1977). Disease and illness distinctions between professional and popular ideas of sickness, *Culture, Medicine and Psychiatry*, 1, 1, pp. 9-23.
- Eleftheriadou, Z. (2015). Proposal to include race, culture and diversity in Counselling Psychology training, *Black and Asian Counselling Psychologists' Group (BACPG)*.
- Ellis, E. & Cooper, N. (2013). Silenced: The Black student experience, *Therapy Today*, 24, 10.
- Ellis, H. (2015). An investigation into Obeah-illness versus psychiatric entities among Jamaican immigrants: Cultural and clinical perspectives for psychiatric mental health professionals, *Archives of Psychiatric Nursing*, 29, 2, pp.83-89.
- El-Nimar, G. Green, L.L. & Salib, E. (2004). Spiritual care in psychiatry: Professionals' views, *Mental Health, Religion & Culture*, 7, 2, pp.165-170.
- English Church Census (2006). *Pentecostalism*. [online]. Available from <http://www.christian-research.org/> [Accessed 13 June 2012].
- Farias, M. Claridge, G. & Lalljee, M. (2005). Personality and cognitive predictors of New Age practices and beliefs, *Personality and Individual Differences*, 39, 5, pp.979-989.
- Ferguson, A. (2016). Mental illness is a stigma within the black community, *The Guardian* (8th February).
- Fernando, S.J.M. & Keating, F. (Eds.), (1995). *Mental Health in a Multi-Ethnic Society: A multidisciplinary handbook*. London: Routledge
- Fernando, S.J.M. (2002). *Mental Health, Race and Culture*. (3rd edition). Hampshire: Palgrave
- Fernando, S.J.M. (2012). Race and culture issues in mental health and some thoughts on ethnic identity, *Counselling Psychology Quarterly*, 25, pp. 113-123.
- Field, H. & Waldfogel, S. (1995). Severe ocular self injury, *General Hospital Psychiatry*, 17, pp. 224-7.
- Foster, E. (1992). Women and the inverted pyramid of the Black churches in Britain. In, G. Sahgal & N. Yuval-Davis, (Eds.) *Refusing Holy Orders: Women and Fundamentalism in Britain*. London: Virago Press.
- Freud, S. (1907). Obsessive Acts and Religious Practice: The origins of religion. Translated by Strachey, J. Dickson, A. (Ed.), London: Penguin Books

- Freud, S. (1913). Totem and Taboo. Germany: Beacon Press
- Freud, S. (1930). *Civilization and Its Discontents*. London: Hogarth Press
- Freud, S. (1989). The Future of an Illusion. New York: W.W. Norton. (Original work published 1927)
- Fryer, P. (1984). *Staying Power*. London: Pluto Press
- Gerloff, R. (2004). The African Christian diaspora in Europe: Implications for mission and ecumenism, with special reference to the global impact of Pentecostal/Charismatic movement, *University of Leeds*
- Gerloff, R. (2010). *A plea for British Black theologies: The Black church movement in Britain in its transatlantic cultural and theological interaction with special reference to the Pentecostal Oneness (Apostolic) and Sabbatarian movements*. Eugene, Oregon: Wipf and Stock.
- Gilbert, P. & Nicholls, V. (2003). Inspiring hope: Recognising the importance of spirituality in a whole person approach to mental health, *Mental Health Foundation*
- Gillborn, D. (2008). *Racism and Education: Coincidence or Conspiracy?* (1st edition). Oxford: Routledge Taylor & Francis Group Ltd
- Good Therapy. (2018). Dance Movement Therapy, *GoodTherapy.org*
- Govier, I. (2000). Spiritual care in nursing: A systemic approach, *Nursing Standard*, 14, pp. 32-36.
- Greasley, P. Chui, L.F. & Gartland, M. (2000). The concept of spiritual care in mental health nursing, *Journal of Advanced Nursing*, 33, 5, pp. 629-637.
- Green, M.L. & Ellis, P.J. (2002). Impact of an evidence-based medicine curriculum based on adult learning theory, *Journal of General Internal Medicine* 12, 12, pp. 742-750.
- Grothaus, M. (2015). Why journaling is good for your health, *Fast Company*.
- Group for the Advancement of Psychiatry (GAP). (1976). *Mysticism: Spiritual Quest or Psychic Disorder?* New York: Group for the Advancement of Psychiatry
- Gundara, J.S. and I. Duffield, (Eds.), (1992). *Essays on the History of Blacks in Britain*. Avebury, Aldershot.
- Hackett, J. (2013). Epigenetic reprogramming, *University of Cambridge*.

- Hansen, F. (2014). Can faith help us cope with stress? *Perfect Health*.
- Harrow, M. Rattenbury, F. & Stoll, F. (1988). Schizophrenic Delusions: An analysis of their persistence of related pre-morbid ideas and of three major dimensions. In T.F Oltmanns, & B.A Maher, (Eds.) *Delusional Beliefs: Interdisciplinary perspectives*. New York: John Wiley and Sons
- Hatton, C. Turner, S. Shah, R. Rahim, N. & J. Stansfield, (2004). Religious expression: A fundamental human right, *Mental Health Foundation*
- Hawley, G. & Irurita, V. (1998). Seeking comfort through prayer, *International Journal of Nursing Practice*, 4, pp. 9-18.
- Hayfield, N. (2017). Thematic Analysis, *Metanoia Institute Research Academy notes*.
- Health and Social Care Information Centre. (2014). A strategy for the Health and Social Care Information Centre 2013 – 2015, *Health and Social Care Information Centre*.
- Helman, C. G. (1981). Disease versus illness in general practice, *Journal of the Royal College of General Practitioners*, 31, pp. 548-552
- Helman, C. G. (1990). *Culture, Health and Illness*. Bristol: Wright
- Helms, J. E. (1995). An update on Helms white and people of colour racial identity models. In J.G. Ponterotto, J.M. Casas, L.A. Suzuki, & C.M. Alexander, (Eds.), *Handbook of Multicultural Counselling*. Thousand Oaks, CA: Sage
- Heritage, J. (1984). *Garfinkel and Ethnomethodology*. Cambridge: Polity
- Hewitt, B. (2010). Religious trends. Christian Research Association. [online]. Available from <http://www.christian-research.org/> [Accessed 13 June 2012].
- Hill, C, (1971). From church to sect: West Indian religious sect development in Britain, *Journal for the Scientific Study of Religion*, 10, 2, pp.114–123.
- Hill, C. (2015). The Spiritual State of the Nation, *Community and Race Relations Booklet*, *British Council of Churches*.
- Hilliard, A.G. (1986). *Review of Blacks in Antiquity: Ethiopians in the Greco-Roman Experience*. In I. Van Sertima, *African Presence in Early Europe*. New Brunswick: Transaction Books
- Hodges, S. D. Humphreys, S.C. & Eck, J.C. (2002). Effect of spirituality on successful recovery from spinal surgery, *Southern Medical Journal*, 95, 12, pp.1381-1384.

- Hollenweger, W. J. (2005). *Pentecostalism: Origins and Developments Worldwide*. Massachusetts: Hendrickson Publishers
- Howard, V. (1987). A report on Afro-Caribbean Christianity in Britain. Leeds, UK: *University of Leeds Department of Theology and Religious Studies Community Religions Project Research Papers*.
- Hunt, S. (2016). Pentecostalism in Britain, series is in collaboration with Africa at LSE, *University of West of England (UWE) Bristol*.
- Hwang, K. Hammer, J.H. & Cragan, R.T. (2009). Extending religion-health research to secular minorities: Issues and concerns, *Journal of Religious Health*, 50, pp. 608-622.
- Inciawar, M. Wintrob, R. Bouchard, L. & Bartocci, G. (2009). *Psychiatrists and Traditional Healers: Unwitting Partners in Global Mental Health*. West Sussex: John Wiley & Sons Ltd
- Ineichen, B. (1991). Schizophrenia in British Afro-Caribbeans: Two debates confused? *International Journal of Social Psychiatry*, 37, 4, pp. 227-232.
- Insel, T. (2011). The global cost of mental illness. *National Institute of Mental Health*.
- Jackson, J. J. (Ed.), (1991). *Life in Black America*. Newbury Park, California: Sage.
- Jacobs, M. (1998). *Psychodynamic Counselling in Action*. London: Sage
- Jilek, W.G & Draguns, J.U. (2008). Interventions by traditional healers: Their Impact and relevance within their cultures and beyond. In U.P. Gielen, J.U. Draguns, J.M. Fish, (Eds.) *Principles of Multicultural Counselling and Therapy*. Florence KY: Routledge
- Johnson, B. Larson, D. & McCullough, M. (2000). A systematic review of the religiosity and delinquency literature: A research note, *Journal of Contemporary Criminal Justice*, 16, pp.32-52.
- Jonas, W.B. & Crawford, C.C. (2003). *Healing Intention and Energy Medicine*. New York: Churchill Livingstone.
- Jones, E. & Watson, J. P. (1997). Delusion, the overvalued idea and religious beliefs: A comparative analysis of their characteristics, *British Journal of Psychiatry*, 170, pp. 381–386.
- Kalathil, J. (2011). Ethnic inequalities, *Catalyst creating excellence in minority health and well-being*, 3, pp. 3.
- Kalilombe, P. (1997). Black Christianity in Britain, *Ethnic and Racial Studies*, 20, 2, pp. 306–324.

- Kelly, G.R. Mamon, J.A & Scott, J. (1987). The health belief model in examining medication compliance among psychiatric outpatients, *Social Science and Medicine*, 25, 11, pp.1205-1211.
- Kent, G. & Wahass, S. (1996). The content and characteristics of auditory hallucinations in Saudi Arabia and the UK: A cross-cultural comparison, *Acta Psychiatrica Scandinavica*, 94, 6, pp. 433-437.
- Kenway, P. & Palmer, G. (2007). Poverty among ethnic groups how and why does it differ? *New Policy Institute Joseph Rowntree Foundation*.
- Kiev, A. (1963). Beliefs and delusions of West Indian immigrants to London, *British Journal of Psychiatry*, 109, pp. 356–363.
- King, D. Nicholls, V. Gilbert, P. (2013). Spirituality is not bad for our mental health, *British Journal of Psychiatry*, 202, 1, pp. 68-73.
- King, M.B. Weich, S. Nazroo, J. & Blizard, R. (2006). Religion, mental health and ethnicity. EMPIRIC – A national survey of England, *Journal of Mental Health*, 15,2, pp. 153-162.
- King, N. & Horrock, C. (2010). *Interviews in Qualitative Research*. London: Sage
- Kingdon, G. & Cassen, R. (2007). Understanding low achievement in English schools (CASE Paper 118), London: *London School of Economics / Centre for Analysis of Social Exclusion*.
- King-Hammond, L. (2013). Christianity's African Roots, *Ebony*
- King-Spooner, S. (2001). The Place of Spirituality in Psychotherapy. In S. King-Spooner & C. Newnes, (Eds.) *Spirituality and Psychotherapy*. Ross-on-Wye: PCCS Books.
- Koenig, H.G. (1988). Religious behaviour and death anxiety in later life, *The Hospice Journal*, 4, 1, pp. 3-24.
- Koenig, H. G. Moberg, D.O. & Kvale, J.N. (1988). Religious activities and attitudes of older adults in a geriatric assessment clinic, *Journal of American Geriatric Society*, 36, 4, pp. 362-374
- Koenig, H.G. McCullough, M. E. & Larson, D.B. (2001). *Handbook of Religion and Health*. Oxford: Oxford University Press
- Koenig, H. G. (2007). Religion and remission of depression in medical in-patients with heart failure/pulmonary disease, *Journal of Nervous and Mental Disease*, 195, pp.389-395.

- Koenig, H.G. (2008). Religion and mental health: what should psychiatrists do? *Psychiatric Bulletin*, 32, p.20.
- Koenig, H. G. (2008). Concerns about measuring "spirituality" in research, *Journal of Nervous and Mental Disease*, 19, 5, pp. 349-355.
- Koenig, H.G. (2009). Research on religion, spirituality, and mental health: A review, *Canadian Journal of Psychiatry*, 54, 5, pp. 283-291.
- Koenig, H.G. King, D. & Carson, V. (2012). *Handbook of Religion and Health*. (2nd edition). Oxford: Oxford University Press.
- Krause, N. & Hayward, R. (2013). Emotional expressiveness during worship services and life satisfaction: Assessing the influence of race and religious affiliation, *Mental Health, Religion & Culture*, 16, 8, pp. 813-831.
- Krueger, R. A. & Casey, M. (2000). *Focus Groups. A practical guide for applied research*. California: Sage.
- Kushner, A. W. (1967). Two cases of autocastration due to religious delusions, *British Journal of Medical Psychology*, 40, pp. 293–298.
- Kvale, S. (1996). Interviews: An introduction to qualitative research Interviewing. In A. Bryman, *Social Research Methods*. (3rd edition). New York: Oxford University Press
- Lago, C. with Thompson, J. (1996). *Race, Culture and Counselling*. Buckingham: Open University Press
- Langridge, D. (2007). *Phenomenological Psychology*. Harlow: Pearson
- Larson D. B. Thielman, S. B. Greenwold, M. A. et al. (1993). Religious content in the DSM–III–R glossary of technical terms, *American Journal of Psychiatry*, 150, pp.1884–1885.
- Larson, D.B. Thielman, S. Greenwold, M.A. (1994). Religious content in the DSM-III-R glossary of technical terms, *American Journal of Psychiatry*, 150,12, pp.1884-5.
- Larson, D. B. Sawyers, J.P. & McCullough, M. (1997). Scientific research on spirituality and health: A consensus report. London, *National Institute for Healthcare Research*.
- Leavey, G. & King, M. (2004). Identity & belief within Black Pentecostalism, *Identity and Health*, pp.37-58.
- Lepping, P. (2008). Religion, psychiatry and professional boundaries, *Psychiatric Bulletin*, 32, p.357.

- Levin, J.S. (1996). How prayer heals: A theoretical model, *Alternative Therapies in Health and Medicine*, 2, pp. 66-73.
- Lewandowski, K.E. Barrantes-Vidal, N. Nelson-Gray, R.O. Clancy, C, Kepley, H.O. & Kwapil, T.R. (2006). Anxiety and depression symptoms in psychometrically identified schizotypy. *Schizophrenia Research*, 83, pp. 225-235.
- Lindeman, M. & Aarnio, K. (2007). Superstitious, magical, and paranormal beliefs: An integrative model, *Journal of Research in Personality*, 41,4, pp.731-744.
- Lindsey, M. (2016). Black mental health is different from white mental health, *Big Thinkers on Mental Health*.
- Lipsky, S. (1978). Internalised oppression, *Journal of Black Re-emergence*, 2, pp. 5-10.
- Littlewood, R. & Kareem, J. (1998). *Intercultural Therapy*. Oxford: Blackwell
- Littlewood, R. & Lipsedge, M. (1982). *Aliens and Alienists: Ethnic minorities and psychiatry*. Harmondsworth, Middlesex: Penguin
- Littlewood, R. & Lipsedge, M. (1989). *Aliens and Alienists: Ethnic Minorities and Psychiatry*. Harmondsworth, Middlesex: Penguin
- Loewenthal, K.M. Cinnirella, M. Evdoka, G. & Murphy, P. (2001). Faith conquers all? Beliefs about the role of religious factors in coping with depression among different cultural-religious groups in the UK, *British Journal of Medical Psychology*, 74, pp. 293-303.
- Loring, M. & Powell, B. (1988). Gender, race and DSM-III: A study of the objectivity of psychiatric diagnostic behaviour, *Journal of Health & Social Behaviour*, 29,1, pp.1-22.
- Lotzof, K. (2018). Cheddar Man: Mesolithic Britain's blue-eyed boy. *Natural History Museum*
- Lowth, M. (2015). Ethnicity and Health, *Patient Professional Reference*.
- Lukoff, D. (2000). DSM-IV religious & spiritual problems, *Psychiatric Bulletin*, 32, 6.
- MacAttram, M. (2017). Black Mental Health UK, *BMH UK*.
- Malek, M. (2011). *Enjoy, Achieve and Be Healthy. The mental health of Black and minority ethnic children and young people*. London: Afiya Trust
- Marrington-Mir, P. & Rimmer, A. (2007). Black and minority ethnic people and mental health in Britain. An holistic approach, *Researchgate*.

- Martín-Merino, E. Ruigómez, A. Wallander, M.A. Johansson, S. & García-Rodríguez, L.A. (2009). Prevalence, incidence, morbidity and treatment patterns in a cohort of patients diagnosed with anxiety in UK primary care, *Family Practice*, 27, 1, pp.9-16
- Mayers, C. Leavey, G. Vallianatou, C. & Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study, *Clinical Psychology and Psychotherapy*, 14, pp. 317–327.
- Mbiti, J.S. (1989). *African Religions and Philosophy*. Oxford: Heinemann
- McCabe, M. S. Fowler, R. C. Cadoret, R. J. Winokur, G. (1972). Symptom differences in schizophrenia with good and poor prognosis, *American Journal of Psychiatry*, 128, pp.1239–1243.
- McCullough, M.E. (1995). Prayer and health: Conceptual issues, research review and research agenda, *Journal of Psychology and Theology*, 23, pp.15-29.
- McGreal, S. A. (2013). Troubled Souls: Spirituality as a mental health hazard, *Psychology Today*.
- McKenzie, K. (2007). Being black in Britain is bad for your mental health, *The Guardian* (2nd April).
- McKenzie-Mavinga, I. (2005). A study of black issues in counsellor training 2002 – 2005, *DProf thesis, Middlesex University*.
- McKenzie-Mavinga, I. (2011). In C. Lago (Ed.) *The Handbook for Transcultural Counselling and Psychotherapy*. Milton Keynes: Open University Press.
- McLeod, J. (2003). *Doing Counselling Research*. London: Sage
- McLeod, J. (2011). *Qualitative Research in Counselling and Psychotherapy*. London: Sage
- McManus, S. Bebbington, P. Jenkins, R. Brugha, T. (Eds.) (2016). Mental health and wellbeing in England, *Adult Psychiatric Morbidity Survey*, Leeds.
- McNicholl, A. (2015). Mental health trust funding down eight per cent from 2010 despite coalition's drive for parity of esteem, *Community Care*, 20.
- McSherry, W. (2000). *Making Sense of Spirituality in Nursing Practice: An interactive approach*. Edinburgh, New York: Churchill Livingstone
- Mental Health Foundation. (2014). *What is mental health*. [online]. London. Available from: <<http://www.mentalhealth.org.uk>> [Accessed 18 February 2014].

- Miller, W.R. (Ed.), (1999). *Integrating Spirituality into Treatment: Resources for practitioners*. Washington DC: American Psychological Association.
- Milstein, G. Manierre, A. & Yali, A.M. (2010). Psychological care for persons of diverse religions: A collaborative continuum, *Professional Psychology Research and Practice*, 41, pp. 371-381.
- Mind. (2017). *Mind*
- Mohr, S. Brandt, P.Y. Borrás, L. Gillieron, C. & Huguelet, P. (2006). Toward an integration of spirituality and religiousness into the psychosocial dimension of schizophrenia, *American Journal Psychiatry*, 163, 11, pp.1952-1959.
- Mohr, S. Perroud, N. Gillieron, C. Brandt, P.Y. Riebel, I. Borrás, L. & Huguelet, P. (2011). Spirituality and religiousness as predictive factors of outcome in schizophrenia and schizoaffective disorders, *Psychiatry Research*, 186, pp.177-182.
- Moll, R. (2014). *The Surprising Links Between Faith and Health: Five ways your faith improves your health*, Florida: RELEVANT Media Group.
- Moodley, R. & Palmer, S. (2006). *Race Culture and Psychotherapy. Critical perspectives in multicultural practice*. Sussex: Routledge
- Moodley, R. Sutherland, P. & Oulanova, O. (2008). Traditional healing, the body and mind in psychotherapy, *Counselling Psychology Quarterly*, 21, 2, pp. 153–165.
- MQ –Transforming Mental Health. (2015). UK mental health - how much do we spend on research? *MQ: Transforming Mental Health Through Research*, London: AMRC
- Muir, R.D. (2015). Theological education and training among British Pentecostals and Charismatics, *Churches Together England*.
- Mushtaq, I. & Hafeez, M.A. (2008). Psychiatrists and role of religion in mental health, *Psychiatric Bulletin*, 32, pp.395.
- Nam, S. (2013). Religious attendance, obesity and self-rated health, *Crossroads* 3, pp.2.
- Narayanasamy, A. (2001). *Spiritual Needs with Prompt Questions in Spiritual Care: A practical guide for nurses and healthcare practitioners*. Wiltshire: Quay Publishing
- NatCen Social Research. (2014). Psychiatric Morbidity Report. *Office of National Statistics*.
- Ndegwa, D. & Olajide, D. (2003). *Main Issues in Mental Health and Race*. Hants: Ashgate Publishing Limited

- Ndetei, D.M. & Vadher, A. (1984). Frequency and clinical significance of delusions across cultures, *Acta Psychiatrica Scandinavica*, 70, pp.73-76.
- Newberg, A. (2010). Neurotheology: This is your brain on religion, *Talk of the Nation*.
- NHS. (1999). National Service Framework for Mental Health. *Department for Health and Social Care*.
- NHS. (2015). Welsh Health Survey, *NHS*
- NHS Choices. (2013). How has the DSM-5 been received in the UK? *NHS Choices*
- NHS Choices. (2017). Black health issues. *NHS Choices*.
- Nicholls, V. (2002). Taken Seriously: The Somerset Spirituality Project: London, *Mental Health Foundation*
- Nicholls, V. & Gilbert, P. (2003). Recognising the importance of spirituality in a whole person approach to mental health, *NIMHE National Project on Spirituality in Mental Health in partnership with the Mental Health Foundation*.
- Office for National Statistics. (2001). *Psychiatric morbidity report*, London: Office for National Statistics.
- Office for National Statistics. (2006). *A Guide to Comparing 1991 and 2001 Census Ethnic Group Data*. London: Office of National Statistics
- Office for National Statistics. (2011). *2011 Census*. London: Office for National Statistics.
- OFSTED. (2002). Achievement of Black Caribbean pupils: Three successful primary schools. *A report from the Office of Her Majesty's Chief Inspector of Schools*.
- Olszewski, M. E. (1994). The effect of religious coping on depression and anxiety in adolescents. *Doctoral dissertation, Corvallis or Valley Library*.
- Oluwole Olofinjana, I. (2012). *The History of Black Majority Churches in London*: Open University
- Osei, G.K. (1999). *African Contribution to Civilization*. Baltimore: Black Classic Press
- Osgood, H. (2012). The Rise of Black Churches. In D. Goodhew, (Ed.) *Church Growth in Britain: 1980 to the Present*. Farnham: Ashgate.
- Palmer, M. (1997). *Freud and Jung on Religion*. New York: Routledge
- Palmer, S. (2008). *Multicultural Counselling*. London: Sage

- Paloma, M. (1993). The effects of prayer on mental well-being, *Second Opinion*, 18, pp. 37-51.
- Pargament, K. I. Smith, B. W. Koenig, H. G. & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors, *Journal for the Scientific Study of Religion*, 37, pp. 710–724.
- Pargament, K. I. Koenig, H. G. & Perez, L. M. (2000). The many methods of religious coping: Development and initial validation of the RCOPE, *Journal of Clinical Psychology*, 56, pp. 519–543.
- Pargament, K.I. (2010). Religion and coping: The current state of knowledge. In S. Folkman, (Ed.) *Oxford Handbook of Stress and Coping*. Oxford: Oxford University Press.
- Pargament, K. I. (2013). What Role do Religion and Spirituality Play in Mental Health? *The American Psychological Association*.
- Park, A. Caroline Bryson, B. & Curtice, J. (Eds), (2014). The British Social Attitudes Survey: The 31st Report, *NatCen Social Research*
- Parker, G. Beresford, B. Clarke, S. Gridley, K. Pitman, R. Spiers, G. & Light, K. Social (2008). Technical Report for SCIE Research Review on the Prevalence and Incidence of Parental Mental Health Problems and the Detection, Screening and Reporting of Parental Mental Health Problems. *Social Policy Research Unit: University of York*.
- Parsons, G. (Ed.), (1993). Growth of Religious Diversity: Britain from 1945. Volume 1. Oxon: Routledge in association with Open University
- Patel, K. (2006). Mental health inquiry, *Community Care*.
- Peck, M.S. (1992). In D. Lukoff, F.G. Lu & R Turner (1995). Cultural considerations in the assessment and treatment of religious and spiritual problems. *Psychiatric Clinics of North America*, 18, 3, pp. 467-485.
- Pedersen, P.B. (1997). *Culture-Centred Counselling Interventions: Striving for accuracy*. London: Sage
- Persaud, A. Dein, S. & Willis, J. (2017). Research in religion, spirituality and health and its clinical implications, *Queen Mary, University of London*
- Peters, E. Day, S. McKenna, J. & Orbach, G. (1999). Delusional ideation in religious and psychotic populations, *British Journal of Clinical Psychology*, 38,1, pp. 83-96.
- Platt, L. (2002). *Parallel lives? Poverty Among Ethnic Minority Groups in Britain*. London: Child Poverty Action Group
- Poole, R. Higgo, R. Strong, G. Kennedy, G. Ruben, S. Barnes, R. et al. (2008). Religion, psychiatry and professional boundaries, *Psychiatric Bulletin*, 32, p. 356.

- Post, S.G. (1992). DSM-III-R and religion, *Social Science & Medicine*, 35,1, pp. 81-90.
- Postnote. (2007). Ethnicity and Health. *Parliamentary Office of Science and Technology*, 276, p. 2.
- Powell, D. (2016). How Black Pentecostal pastors conceptualise mental health helps us with the notion of healing from a Black church perspective. Unpublished dissertation, findings presented at Healing Our Broken Village Black Metal Health Conference 27th October 2016, *Wandsworth Community Empowerment Network*
- Propst, L. Ostrom, R. Watkins, P. et al. (1992). Comparative efficacy of religious and nonreligious cognitive-behavioural therapy for the treatment of clinical depression in religious individuals, *Journal of Consulting and Clinical Psychology*, 60, pp.94–103.
- Purton, C. (1998). Unconditional Positive Regard and its Spiritual Implications. In B. Thorne & E. Lambers, (Eds.) *Person-centred Therapy: A European perspective*. London: Sage.
- Quam, R. (2018). The earliest modern humans outside Africa, *Science Magazine*.
- Raji, O. (2004). Prayer and medicine, a healthy alliance? A multi-faith, multi-cultural perspective, *Research Paper*.
- Rath, L. (2018). The health benefits of dancing, *Living Well: Bupa UK*.
- Recovery Across Mental Health (RAMH). (2017). Gender differences in mental health, *RAMH*
- Redd, D. (1979). Black Madonnas of Europe: Diffusion of the African Isis (AUSER), *African Renaissance Foundation*
- Reddie, A. (2006). *Black Theology in Transatlantic Dialogue*. New York: Palgrave Macmillan
- Rehman, H. & Owen, D. (2013). Mental health survey of ethnic minorities summary of insights method, *Mental Health and Ethnic Minorities*.
- Rethink Mental Illness. (2013). Spirituality, religion and mental illness, *Rethink*
- Rettner, R. (2015). God help us? How religion is good (and bad) for mental health, *Live Science*.
- Rogers, A. (2016). Being Built Together, *Southwark Research*.
- Rosmarin, D.H. Pirutinsky, S. Pargament, K. I. & Krumrei, E. J. (2009). Are religious beliefs relevant to mental health among Jews? *Psychology of Religion and Spirituality*, 1, pp.180-190.

- Saldana, J. (2016). *The Coding Manual for Qualitative Researchers*. London: Sage
- Saucier, G. & Skrzypińska, K. (2006). Spiritual but not Religious? Evidence for Two Independent Dispositions, *Journal of Personality*, 74(5), pp.1257-1292.
- Scazzero, P. (2015). *The Emotionally Healthy Leader*. Grand Rapids Michigan: Zondervan
- Schwartz, C. (2003). Altruistic social interest behaviours associated with better health, *Psychodynamic Medicine*, 65, pp.778-785.
- Scott, R. (2013). *Christians in the Firing Line*. London: Wilberforce Publications
- Scott, R. (2014). Religion benefits health, *British Journal of General Practice*, 64, 624, p. 353.
- Scott Peck, M. (1990). DSM-IV religious and spiritual problems, *Spiritual Competency Resource Centre*.
- Shaw, A. Joseph, S. & Linley, P. A. (2005). Religion, spirituality, and posttraumatic growth: A systematic review, *Mental Health, Religion & Culture*, 8, 1, pp. 1-11.
- Shrieve-Neiger, A.K. & Edelstein, B.A. (2004). Religion and anxiety: A critical review of the literature, *Clinical Psychology Review*, 24, pp. 379-397.
- Siddle, R. Haddock, G. Tarrier, N. & Faragher, E.B. (2002). Religious delusions in patients admitted to hospital with schizophrenia, *Social Psychiatry and Psychiatric Epidemiology*, 37, 3, pp.130–138.
- Sims, A. (2003). *Symptoms in the Mind: An introduction to descriptive psychopathology*. (3rd edition). Edinburgh: Saunders Ltd
- Sims, A. (2012). *Religious Delusions*. Royal College of Psychiatrists.
- Sloan, R. P. Bagiella, E. & Powell, T. (1999). Religion, spirituality and medicine, *Lancet*, 353, pp. 664- 667.
- Smith, T.B. McCullough, M.E. & Poll, J. (2003). Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events, *Psychological Bulletin*, 129, 4, pp. 614-636.
- Snowden, F. M, Jr. (1970). *Blacks in Antiquity: Ethiopians in Greco-Roman experience*. Harvard University Press: Belknap Press

- Strand, S. (2010). School effects and ethnic, gender and socio-economic gaps in educational achievement at age 11, *Oxford Review of Education*, 40, 2, pp. 131-171.
- Strauss, J. S. (1991). The person with delusions, *British Journal of Psychiatry*, 159, 14, pp. 57–61.
- Sturge, M. (2005). Look what the Lord has done! An exploration of black Christian faith in Britain, *Bletchley: Scripture Union*, 53.
- Sturges, J. E. & Hanrahan, K. J. (2004). Comparing telephone and face -to-face interviewing: A research note, *Qualitative Research*, 4, pp. 107-18.
- Swinton, J. (2001). *Spirituality and Mental Health Care: Rediscovering a forgotten dimension*. London: Jessica Kingsley
- Synan, V. (1997). *The Holiness-Pentecostal Tradition: Charismatic Movements in the Twentieth Century*. Lake Mary Florida: Creation House.
- Szasz, T.S. (1976). Schizophrenia: the sacred symbol of psychiatry, *British Journal of Psychiatry*, 129, pp. 308-316.
- Szasz, T. (1977). *Psychiatric Slavery*. New York: Free Press
- Tackey, N.D. Barnes, H. & Priya Khambhaita, P. (2011). Poverty, ethnicity and education, *JRF programme paper: Poverty and ethnicity*
- Tarakeshwar, N. Pargament, K.I. Mahoney, A. (2003). Measures of Hindu pathways: development and preliminary evidence of reliability and validity, *Cultural Diversity and Ethnic Minority Psychology*, 9, pp. 316-332.
- Tateyama, M. Asai, M. Kamisada, M. Hashimoto, M. Bartels M. & Heimann, H. (1993). Comparison of schizophrenia delusions between Japan and Germany. *Psychopathology*, 26, 3, pp.151- 158.
- Taylor, E.J. (2003). Prayer's clinical issues and implications, *Holistic Nursing Practice*, 17, 4, pp.179-188.
- Taylor, S. (1998). Coping Strategies, *Psychosocial Working Group*.
- Terry, G. Hayfield, N. Clarke, V. & Braun, V. (2017). Thematic Analysis. In C. Willig & R. W. Stainton (Eds.) *The Sage Handbook of Qualitative Research in Psychology*. (2nd edition). London: Sage

- Thachil, A & Bhugra, D. (2009). In M. Incayawar, R. Wintrob, L. Bouchard & G. Bartocci. *Psychiatrists and Traditional Healers: Unwitting partners in global mental health*. West Sussex: John Wiley & Sons Ltd
- Thara, R. & Eaton, W. W. (1996). Ten year outcome of schizophrenia – the Madras longitudinal study. *Australian and New Zealand Journal of Psychiatry*, 30, pp.482–488.
- The Holy Bible. King James Version
- The Race Relations Act 1976 (Amended Act 2000) (Commission for Racial Equality 2002)
- Thomas, A. (1998). The Stresses of Being a Counsellor Trainer. In H. Johns (Ed.) *Balancing Acts: Studies in counselling training*. London: Routledge
- Thomas, A. & Sillen, S. (1972). *Racism and Psychiatry*. Secaucus, New Jersey: Citadel Press
- Thuné-Boyle, I. (2010). Religious coping strategies in patients with breast cancer in the UK, *Psycho-Oncology*, 10,1002, p.1784.
- Tiedmann, M. (2013). Ed Miliband visits Brixton Hill to pay tribute to Nelson Mandela, *Lambeth Labour*.
- Time To Change. (2014). Black and minority ethnic communities faced with double levels of discrimination report, London: *Mind and Rethink Mental Health*.
- Torres, H. (2016). Christianity in U.K. sees 'seismic shift' as Pentecostal and charismatic churches thrive replacing aging churches, *Christianity Today*.
- Torress, H (2016). Christians Packing Churches in India as Christianity Sees Surprising Growth Despite Rising Persecution Cases, *London: Christian Today*
- Toulis, N. (1997). *Believing Identity: Pentecostalism and the mediation of Jamaican ethnicity and gender in England*. Oxford: Berg
- Trivedi, P. (2002). *Racism, social exclusion and mental health: A black service user's perspective*. London: Jessica Kingsley Publishers.
- Trotman, A. (1992). Who is our Neighbour? In J. Edwards, *Let's Praise Him Again*. London: Kingsway Publications
- Tseng, W.S. & Hsu, J. (1979). Culture and psychotherapy. In A.J. Marsella, R.G. Tharp & T.J. Caborowski, (Eds.) *Perspectives in cross-cultural psychology*. New York: Academic Press

- Tuckwell, G. (2002). *Racial Identity, White Counsellors and Therapists*. Buckingham: Open University Press
- Turbott, J. (2004). Religion, spirituality and psychiatry: Steps towards rapprochement, *Australasian Psychiatry*, 12, 2, pp.145-147.
- Turner, H. (1987). Pocomania New Religious Movements in the Caribbean. In V. Howard, *A report on Afro-Caribbean Christianity in Britain*. University of Leeds.
- Van Praag, H. M. (2009). The role of religion in suicide prevention. In Wasserman D, Wasserman C, (Eds.) *Oxford Textbook of Suicidology and Suicide Prevention*. Oxford: Oxford University Press.
- VanderWeele, T.J. (2017). Causal effects of religious service attendance? *Social Psychiatry and Psychiatric Epidemiology*, 52, 11, pp.1331-1336.
- Van Sertima, I. (1976). *They Came Before Columbus*. New York: Random House
- Van Sertima, I. (1986). *African Presence in Early Europe*. New Brunswick: Transaction Books
- Vossler, A. & Moller, N. (2015). *The Counselling and Psychotherapy Handbook*. London: Sage
- Waugh, A.C. (1986). Autocastration and biblical delusions in schizophrenia, *British Journal of Psychiatry*, 149, pp.656-658.
- We Still Need To Talk. (2014). Access to talking therapies, *We need to talk coalition*, London: Mind
- Welch, G. (2015). The benefits of singing in a choir. *City of London Festival. Lecture Gresham College*, < <https://www.gresham.ac.uk/lectures-and-events/the-benefits-of-singing-in-a-choir> >
- Welchel, T. & Griffith, M.P. (2013). *True Stories of the Miracles of Azusa Street and Beyond*. Shippensburg, PA: Destiny Image Publishers.
- White, G. (2006). *Talking about the Spirituality in Healthcare Practice: A resource for the multi-professional health care team*. London and Philadelphia: Jessica Kingsley Publishers
- Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in theory and method*. Buckingham: Open University Press
- Wilson, M. & Bhugra, D. (2010). Patient assessment: incorporating faith and spirituality, *Royal College of Psychiatrists*, 1, p. 8.

Wink, P. Dillon, M. & Larsen, B. (2005). Religion as a moderator of depression – health connection, *Sage Journals*, 27, 2, pp.197-220.

Winslow, G. R. Winslow, B.W. (2003). Examining the ethics of praying with patients, *Holist Nursing Practice*, 17, pp. 170-177.

Wintrob, R. (2009). Overview: Looking toward the future of shared knowledge and healing practices. In M. Incayawar, R. Wintrob, L. Bouchard & G. Bartocci. *Psychiatrists and Traditional Healers: Unwitting Partners in Global Mental Health*. West Sussex: John Wiley & Sons Ltd

World Health Organization. (2016). The ICD-10 International Classification of Disease, Tenth Revision (ICD-10). Hendon V.A.: Stylus Publishing, LLC

Yawney, C.D. (2004). The African Christian Diaspora in Europe: Religious and Cultural aspects. In R. Gerloff, *The African Christian diaspora in Europe: Implications for mission and ecumenism, with special reference to the global impact of Pentecostal/Charismatic movement*. University of Leeds

Yong, A. (2006). Justice deprived, justice demanded: Afro- Pentecostals and the task of world Pentecostal theology today, *Journal of Pentecostal Theology*, 15, 1, pp. 127-147.

Young Minds. (2014). *Children's mental health funding not going where it should be*, Young Mind. Available from: < <https://youngminds.org.uk/about-us/media-centre/press-releases/>> [Accessed 23rd June 2016].

Zahid, N. (2017). Can transcultural therapy address the issues of racism within psychotherapy? *Surrey: Counselling Directory*

